UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK

In re	:	**Chapter 11 Case No.**
MOTORS LIQUIDATION COMPANY, *et al.*, f/k/a General Motors Corp., *et al.*	:	**09-50026 (REG)**
Debtors.	:	**(Jointly Administered)**

DECLARATION OF JOSEPH H. SMOLINSKY IN SUPPORT OF MOTORS LIQUIDATION COMPANY GUC TRUST'S REPLY TO RESPONSES TO THE 83rd OMNIBUS OBJECTION TO CLAIMS (WELFARE BENEFITS CLAIMS OF RETIRED AND FORMER SALARIED AND EXECUTIVE EMPLOYEES) (PROOF OF CLAIM NUMBER 62922 FILED BY CLAIMANT LINDA K. BELLAIRE)

I, JOSEPH H. SMOLINSKY hereby declare as follows:

1. I am a partner at Weil, Gotshal & Manges LLP, Attorneys for Motors Liquidation Company GUC Trust (the "**GUC Trust**"), formed by the above-captioned debtors (collectively, the "**Debtors**")[1] in connection with the *Debtors' Second Amended Joint Chapter 11 Plan*, dated March 18, 2011. I respectfully submit this Declaration based upon my personal knowledge and my preparation of the documents in support of the GUC Trust's *Reply to Responses to the 83rd Omnibus Objection to Claims (Welfare Benefits Claims of Retired and Former Salaried and Executive Employees).*

2. Attached herewith as **Annex "A"** is a true and correct copy of that certain Publication 3.GM-H-425G.104, which is the summary plan description of the Welfare Benefit

[1] The Debtors are Motors Liquidation Company (f/k/a General Motors Corporation) ("**MLC**"), MLCS, LLC (f/k/a Saturn, LLC), MLCS Distribution Corporation (f/k/a Saturn Distribution Corporation), MLC of Harlem, Inc. (f/k/a Chevrolet-Saturn of Harlem, Inc.), Remediation and Liability Management Company, Inc. ("**REALM**"), and Environmental Corporate Remediation Company, Inc. ("**ENCORE**").

Plans provided to retired GM salaried employees, entitled "*Your Benefits in Retirement Summary Plan Description: A Handbook for Salaried Retirees in the United States*". The publication is referred to in the response filed on behalf of Linda K. Bellaire (ECF No. 6972).

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge, information, and belief.

Dated: New York, New York
February 24, 2012

/s/ Joseph H. Smolinsky
JOSEPH H. SMOLINSKY

Annex A

Your Benefits in Retirement
Summary Plan Description

A Handbook for Salaried Retirees in the United States

Dear GM Salaried Retiree:

As a GM salaried retiree, you and your eligible survivors have one of the finest and most comprehensive benefit packages in the industry. This updated booklet, "Your Benefits in Retirement," summarizes these benefit options. There are detailed information and instructions to help you manage your benefits and make the best choices for your personal situation.

Your benefits are an important element in your financial planning and in securing the health and future for you and your family. The information in this booklet can serve as a reference tool and answer questions you may have about your benefit options. It will also help you make important benefit decisions.

If you should have any questions regarding the material covered in this booklet, please contact the appropriate activity as listed on page 3.

Sincerely,

Kathleen S. Barclay
Vice President
Global Human Resources

This booklet presents general information only and is designed to give you a broad picture of the added value of having worked with General Motors. It is not a contract and does not modify the terms of any benefit plan or program. Any reference to the payment of benefits is conditioned upon your eligibility to receive them. Each of these Programs or Plans has its own terms and conditions which in all respects control the benefits provided.

Information in this booklet applies to GM salaried retirees with a service date prior to January 1, 2001 (unless otherwise noted) and their eligible dependents. Some, but not all, of the information in this booklet also applies to the eligible surviving spouse of a deceased employee or retiree. Information applicable to eligible surviving spouses is noted in the text of the booklet. This booklet ***does not*** apply to individuals who terminated their employment with GM prior to being eligible to retire but who may be eligible to receive a deferred vested retirement benefit.

General Motors Corporation reserves the right to amend, change, or terminate the Plans and Programs described in this booklet. The Plans and Programs can be amended only in writing by an appropriate committee or individual as expressly authorized by the Board of Directors. No other oral or written statements can change the terms of a benefit Plan or Program.

FOR BENEFITS INFORMATION AND ASSISTANCE

GM Benefits & Services Center (GM BSC)
gmbenefits.com
1-800-489-GMGM (4646)
TTY - 1-877-347-5225

The GM Benefits & Services Center (GM BSC) is the best source of information for the programs listed below:

RETIREMENT PROGRAM

HEALTH CARE RELATED SERVICES
- Health Care
- Extended Care
- Dental
- Vision
- Prescription Drug
- COBRA

REPORTING A DEATH/SURVIVOR SERVICES

LIFE INSURANCE
- Basic Life
- Optional Life
- Dependent Life
- Personal Accident

SAVINGS-STOCK PURCHASE PROGRAM (S-SPP)

STOCK OPTIONS

PLEASE NOTE: Programs whose services are <u>not</u> administered by the GM BSC may be accessed at the websites and phone numbers below:

	WEBSITE	PHONE #
• **Mental Health/Substance Abuse**		1-888-865-2960
• **Care Management**		1-877-299-4635
• **Wellness & Health Promotion – LifeSteps**	www.lifesteps.com	
ADDITIONAL SAVINGS PLANS		
• College 529 Plans		
Fidelity Investments	http://fidelity.com/goto/collegesave	1-800-544-2270
Putnam	http://www.gmira.com	1-800-634-1591
TIAA CREFF	http://www.529Michigan.com	1-888-529-4461
• GMAC Demand Notes	www.demandnotes.com	1-888-271-4066
• Personal Retirement Income Plan (Putnam)	www.gmira.com	1-800-343-0909
VEHICLE PROGRAMS		
• Vehicle Purchase Plan	www.gmfamilyfirst.com	1-800-235-4646
• Smart Lease Program	www.gmacfs.com	1-800-327-6278
• GM Protection Plan	gmppdirect.com	1-800-981-4677
• Motors Insurance Corporation (MIC)	www.gmacfs.com	1-800-642-6464
OTHER PROGRAMS & SERVICES		
• Financial Planning (AYCO)	www.aycofinancialnetwork.com/clients/mim	1-800-437-6383
• Long Term Care (John Hancock)		1-800-200-6773 1-800-255-1808 (TTY)
• Medicare	www.medicare.gov	1-800-MEDICARE
• Social Security Administration	www.socialsecurity.gov	1-800-772-1213 1-800-325-0778 (TTY)
• GMAC Bank Education Loans	www.edloans.gmacbank.com	1-800-500-9876

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Your Retirement Income

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Your Retirement Income

Any retirement benefits you may be eligible to receive as a retired GM employee or surviving spouse are based on the provisions of the GM Salaried Retirement Program in effect when you, or your deceased spouse, retired. However, the benefit amounts may have been increased from time to time, depending on the date you, or your deceased spouse, retired or died.

Your GM Salaried Retirement Program is made up of two parts — Part A and Part B.

Any Part A benefits that you may be receiving are noncontributory. The entire cost of providing these benefits is paid for by GM. The benefits provided under Part A of the Program are comparable to those provided under the Hourly-Rate Employees Pension Plan.

Any Part B benefits that you may be receiving are in addition to any Part A benefits. To be eligible for Part B benefits, you must have contributed while eligible and left your contributions in the Program until retirement. Part B consists of two components — primary benefits, which are based on the amount you have contributed, and supplementary benefits, which are based on your average base salary, generally over the 60 months preceding your retirement. While you must have contributed in order to have participated in Part B of the Program, GM also contributes, in the aggregate, approximately 85% of the cost of this part of the Program.

Further information regarding benefits that may be payable to your surviving spouse in the event of your death begins on page 90 of this booklet.

Retirement Program benefits generally are in addition to Social Security benefits (see page 13). References to Social Security in this booklet are based on the federal law in effect in January 2000. Any questions you have regarding Social Security should be referred to your local Social Security office.

The following pages provide information that is responsive to questions that have been asked by retirees and surviving spouses. If you do not find answers to your specific questions, you may wish to contact the GM Benefits & Services Center by calling 1-800-489-4646, or visit the GM Benefits & Services Center website at gmbenefits.com. You can write to the GM Benefits & Services Center at P.O. Box 770003, Cincinnati, OH 45277-0066.

Part A Benefits

Retirement Benefit Amount Under Part A of the Retirement Program

The items used in the calculation of your monthly Part A retirement benefit include the following:

- Type of retirement
- Date of retirement
- Benefit rate
- Years of credited service
- Age at time of retirement
- Surviving spouse coverage.

The information used to calculate your monthly retirement benefit is set forth on your copy of the retirement authorization form you signed at retirement. This form shows how your retirement benefits were calculated.

A signed copy of this form was given to you at the time you retired or became an eligible surviving spouse.

You are notified by letter of any adjustments to your Part A retirement benefits after you retire. These letters, showing the revised benefit amounts, should be kept with your retirement form.

Components of the Part A Retirement Benefit

Each monthly Part A retirement benefit is composed of one, or more, of the following:

- Basic benefit (below)
- Supplement (next column)
- Temporary benefit (see next column and page 9)
- Special benefit (see page 9).

Part A Basic Benefit

The basic benefit is a noncontributory lifetime benefit payable each month to a retired employee. It also is the amount on which any Part A surviving spouse benefit is based.

The basic benefit amount is determined by multiplying the applicable basic benefit rate by your years of credited service. This benefit may be reduced because of your age at benefit commencement. It also will be reduced if you have surviving spouse coverage in effect.

Part A Supplements and Temporary Benefits

Part A supplements are amounts paid monthly in addition to basic benefits. The interim supplement is in addition to the Part A basic benefit. The early retirement supplement is intended to bring your total monthly benefit up to a certain level. The temporary benefit is payable in the case of total and permanent disability retirement or window programs. All may be paid until you attain age 62 and one month.

If you retired between March 1, 1974, and September 1, 1979, you may be eligible for (1) an age-service supplement or (2) a lifetime supplement. These supplements are payable each month for life.

Supplements are not payable to you if you are discharged.

Reduction of Part A Retirement Supplements for Reasons Other Than Age

If you are receiving an early retirement supplement, any increase in your basic and temporary benefits will result in a corresponding decrease in your supplement.

If you retired voluntarily and become eligible for a Social Security Disability Insurance Benefit, any supplement you are entitled to receive before age 62 and one month will be reduced. The amount of the reduction will equal the amount of the temporary benefit in effect at the time of your Social Security Disability Insurance Benefit Award (see page 13).

If you become eligible for a Social Security Disability Insurance Benefit, you should immediately advise the GM

Benefits & Services Center by calling 1-800-489-4646. This will help prevent an overpayment of GM benefits that you would have to repay.

Part A supplements are reduced by the amount of any monthly Part B supplementary benefit payable to you.

If you retired between March 1, 1974, and September 1, 1979, with 30 or more years of credited service, you may receive a monthly Part A lifetime supplement not to exceed $35.00 when added to Part B supplementary benefits payable at retirement.

Eligibility for Part A Temporary Benefits

If you retired prior to age 62 (1) because of total and permanent disability, (2) under conditions mutually satisfactory to you and GM, or (3) as a "special early" retirement, you may be eligible to receive a monthly temporary benefit. The temporary benefit would be in addition to any Part A basic benefits or supplements for which you may be eligible. If you retired under a "Window" provision on or after October 1, 1987, you also may be eligible for a monthly temporary benefit.

The amount of the monthly temporary benefit is based on your years of credited service at retirement, up to 30 (25 for retirements prior to January 1, 1983), and the temporary benefit rate, as determined by your retirement date.

The temporary benefit is payable to age 62 and one month (age 65 if you retired before June 1, 1974). In no event, however, will the temporary benefit be payable after you become eligible, or could have become eligible, for a Social Security Disability Insurance Benefit. If you are approved for Social Security Disability Insurance Benefits, the temporary benefit ceases to be payable.

Eligibility for Special Benefit

Each retired employee and eligible surviving spouse who is age 65 or over and receiving a monthly Part A basic retirement benefit, or a surviving spouse benefit related to Part A, may be eligible to receive a Special Benefit, equal to the lesser of the generally applicable Medicare Part B premium, or $76.20 for months commencing on or after January 1, 2004.

This benefit also is payable, upon application, to a retiree or eligible surviving spouse who is (1) receiving a Part A basic retirement benefit, (2) under age 65, and (3) enrolled in Medicare Part B.

Since 1988, retirees and surviving spouses newly eligible for the Special Benefit have been required to enroll (and to maintain enrollment) in Medicare Part B as a condition for receipt of the benefit. Under current Federal tax law, when Medicare enrollment is required as a condition for receipt of the benefit, the benefit is not taxable. If these individuals fail to enroll, payment does not commence; if they enroll initially but later drop out of Medicare Part B, the Special Benefit is discontinued and is not reinstated unless/until Medicare Part B enrollment is resumed.

A small group of retirees and surviving spouses who were receiving a Special Benefit as of October 1, 1990, but who were not enrolled in Medicare Part B, have been allowed to continue receipt of a Special Benefit. However, the maximum amount for these individuals is $28.00 per month and the amount is taxable. If individuals in this group subsequently enroll in Medicare Part B, they become eligible for the greater amount and for the favorable tax treatment.

The Special Benefit is provided under the Health Care Program for individuals retiring on and after October 1, 1979, but is included in the monthly retirement check. Not more than one Special Benefit is payable to any individual for any one month under all GM plans or programs.

Part B Benefits

Components of Part B Retirement Benefit

Each monthly Part B benefit includes a primary benefit. It also may include a supplementary benefit.

The primary benefit is based on a percentage of your Part B contributions made during your active employment.

The supplementary benefit is based on a percentage of your average monthly base salary in excess of specified amounts, times your Part B credited service.

Retirement Benefit Amount Under Part B of the Retirement Program

Any benefits you may be receiving under Part B of the Retirement Program are based on the following:

- Type of retirement
- Date you retired
- Number of years you participated
- Age at retirement
- Whether you contributed at all times while eligible
- Amount of your contributions in the Program
- Average monthly base salary, as defined in the Retirement Program in effect when you retired
- Surviving spouse coverage election.

The amount and calculation of your Part B primary benefit is shown on your retirement authorization form. Copies of all applicable forms were given to you at the time you retired, or became an eligible surviving spouse.

If you did not contribute to your retirement under Part B, your monthly Part A basic benefit is not affected. It is the same, whether or not you contributed under Part B.

Disposition of Part B Contributions

Your contributions and the Corporation's contributions were paid over to the salaried retirement trust. These monies are invested and payments are made to you, or to your surviving spouse or designated beneficiary, according to the terms of the Program.

Total and Permanent Disability Retirement

If you retired because of total and permanent disability, your monthly Part A basic and Part B benefits are the same as if you had retired at age 65. Your benefits are based on your (1) credited service, (2) average monthly base salary, and (3) Part B contributions at the time of your disability retirement. In addition, if Social Security determines that you are not eligible for disability benefits under the Social Security Act, you may receive a temporary benefit from GM (see page 9).

If you are under age 65 and are receiving a total and permanent disability retirement benefit, this benefit will cease to be payable if you (1) are no longer totally and permanently disabled or (2) become gainfully employed for purposes other than rehabilitation. In either event, you should notify the GM Benefits & Services Center by calling 1-800-489-4646.

Changing Type of Retirement After Retirement Effective Date

The type of retirement under which you retired generally will be retained throughout your retirement years.

Assignment of the Benefits Under the Retirement Program

You cannot assign your rights under the Retirement Program to anyone else. ***However, a court may assign a part, or all, of your monthly benefits under a Qualified Domestic Relations Order.***

Effect of Workers' Compensation on Retirement Benefits

Workers' compensation benefits paid to retired employees will be deducted from any Part A retirement benefits otherwise payable.

This deduction also is applicable to any supplementary benefits you may be receiving under Part B of the Retirement Program.

Death or Divorce of Spouse

If you have surviving spouse coverage in effect, as discussed on page 91, you may revoke such coverage in the event your designated spouse dies. Generally, your Part A basic benefit will be restored to the amount payable without the coverage on the first of the month following the date of the death of your spouse upon receipt by GM, of evidence satisfactory to GM, of your spouse's death. Part B benefits are not restored to the amount payable without the survivor coverage in the event you outlive your spouse.

You may rescind the surviving spouse coverage in the event you become divorced by final court decree, and either a qualified domestic relations order so provides or your former spouse agrees. Restoration of your benefits is effective on the first of the month following the month in which proper notice and documents are received by GM.

Election of Survivor Coverage Following Marriage or Remarriage

If you retired on or after January 1, 1962 and did not reject the Part A surviving spouse coverage at any time it was made available to you, you may be eligible to elect, or re-elect, Part A surviving spouse coverage with respect to your new spouse. In all cases, the coverage would provide benefits under the terms and conditions of the program that were in effect at the time you retired.

The coverage will become effective on the one-year anniversary of the marriage.

To elect, or re-elect, the coverage, contact the GM Benefits & Services Center at 1-800-489-4646.

IMPORTANT — This coverage will not become effective if your completed election form is received by GM after the 18-month anniversary of the marriage. The marriage/remarriage provision is not applicable to Part B benefits.

If You Return to Work for GM

Your monthly retirement benefits will cease to be paid to you upon return to work with GM or any of GM's wholly-owned or substantially wholly-owned subsidiaries. Your health care and life insurance coverages provided during retirement also will cease. You may be eligible immediately to accrue additional credited service and be eligible for whatever benefits and coverages are provided at your employing location. GM retirement benefits, health care and life insurance coverages then in effect will be reinstated upon your subsequent retirement.

Receipt of Monthly GM Retirement Check

Generally, retirement checks are mailed by the trustee to the retiree or surviving spouse three business days prior to the end of each month. Therefore, you should receive your check during the first week of each month. If you do not receive your check on or after the eighth of the month, you should contact the GM Benefits & Services Center. A stop payment will be placed on it. Thereafter, a new check will be issued to you within two business days.

If you have a banking agreement in effect, generally your retirement benefits will be transmitted electronically (EFT) to your bank on the first business day of each month. You will receive, at your legal address of record, an advice notice confirming your benefit amount and any deductions. If you do not receive your funds by the second business day, you should contact the GM Benefits & Services Center.

Banking Agreements

A banking agreement is an arrangement you may elect so that your monthly retirement benefit will be deposited directly into your bank account. Direct deposit can help to prevent lost or stolen checks. If you are interested in a banking agreement, ask your bank if they have facilities for this procedure. If your bank permits this procedure, you can obtain a banking agreement form by contacting the GM Benefits & Services Center.

Notification of an Address Change

Any time you change your address, you should notify the GM Benefits & Services Center by calling 1-800-489-4646. This address change will be used by GM to update all other GM benefit systems. A correct home address helps to ensure that you will receive all the information GM sends to you.

Necessary Information to Identify Particular Retirement File

Whenever you contact GM or the GM Benefits & Services Center, you should include your Social Security number. Surviving spouses should include the Social Security number of their deceased spouse.

Taxes

Federal Income Taxes

Your retirement benefits are subject to Federal Income Tax, however, under IRS regulations, if you made contributions to Part B of the Program, you are not subject to tax on a portion of your benefits. The taxable amount of benefits you receive each year will be shown on your annual form 1099R.

If you retired because of total and permanent disability, you may be eligible for a special income tax credit.

For further information relative to the Federal income tax status of your retirement benefits, you may wish to consult (1) your tax advisor, (2) IRS Publication 575, or (3) the instructions for U.S. Individual Income Tax Return (Form 1040) covering pension and annuity income.

Federal Income Tax Withholding

Federal income tax will be withheld from your GM retirement benefits unless you request no withholding be made. If you do not wish to have Federal income tax withheld from your GM retirement benefits, you must request no withholding on U.S. Treasury Form W-4P. This form is available at your local Internal Revenue Service office. You also may obtain this form by calling the GM Benefits & Services Center at 1-800-489-4646, or by visiting their website at gmbenefits.com. You should read carefully the instructions for the form before completing it. The completed form should be sent to the GM BSC. Once begun, withholding will continue until you request in writing that it be terminated, or until you file a

new form increasing, or decreasing, the amount of withholding.

If you are living in the U.S., or a foreign country, but you are not a U.S. citizen, a special foreign tax withholding may apply. Questions regarding foreign tax withholding should be directed to your tax advisor.

The Retirement Program trustee is required to file Form 1099R (Distributions from Pensions Annuities, Retirement, or Profit Sharing Plans, IRA's, Insurance Contracts, etc.) with the Internal Revenue Service for all persons who receive retirement benefits during a calendar year. A copy of the form filed with the Internal Revenue Service will be furnished to you.

State and Local Income Taxes

Your retirement benefits may be subject to state and local income taxes. However, not all state and local jurisdictions impose an income tax on retirement benefits received by individuals. In addition, other jurisdictions exempt all, or a portion, of retirement payments from income tax. Because of these differences, you should consider any taxability of your retirement benefits in light of the laws in effect in your particular state and local jurisdiction.

For further information relative to the tax status of your retirement benefits, you may wish to consult instructions for applicable state and local income tax returns, or your tax advisor.

Social Security Benefits

Your Social Security Benefits

Your Social Security benefits generally are in addition to GM retirement benefits for which you might be eligible. You and GM contributed equally to the cost of Social Security benefits. Social Security Retirement Insurance Benefits may begin as early as age 62 in a permanently reduced amount. For retirees who attain age 65 prior to the year 2003, benefits are payable in full if they begin at, or after, age 65. Effective January 1, 2003, receipt of an unreduced Social Security benefit is dependent on the year of your birth and the age at which you retire.

Your GM Part A basic retirement benefits are not affected by your eligibility for Social Security. However, the supplements and temporary benefit are reduced, or eliminated, if you become eligible for a Social Security Disability Insurance Benefit.

If you retired (1) because of total and permanent disability, (2) under conditions mutually satisfactory to you and General Motors, or (3) as a "special early" retirement, and become eligible for a Social Security Disability Insurance Benefit, you should notify the GM Benefits & Services Center. Prompt notification may prevent an overpayment of GM benefits, which you would have to repay.

Your Spouse's Social Security Benefits

Your spouse may be eligible for a Social Security benefit based on your spouse's own wage record. If not so eligible, your spouse's monthly Social Security benefit at age 65 generally will be equal to one-half of your unreduced monthly Social Security benefit. Your spouse may receive a permanently reduced benefit commencing as early as age 62. A reduced widow's or widower's benefit is payable as early as age 60.

Receipt of Social Security Disability Benefits

If you are disabled, you may be eligible to receive Disability Insurance Benefits from Social Security at any age before age 65. You should consider applying for Social Security Disability Insurance Benefits for the reasons set forth on page 78.

Your nearest Social Security office can tell you if you qualify. Benefits may be payable

after you have been disabled for five full calendar months.

If you become eligible for Social Security Disability Insurance Benefits, you should immediately notify the GM Benefits & Services Center. The notice is necessary to avoid, or minimize, any overpayment of GM benefits, which you would have to repay.

Disqualification, Ineligibility, Denial, Loss, Forfeiture, Suspension, Offset, Reduction or Recovery of Benefits

The following circumstances may result in disqualification, ineligibility, denial, loss, offset, suspension, reduction or recovery of benefits. The circumstances include but are not limited to:

- Insufficient credited service; Impartial Total & Permanent Disability Retirement Examinations; offsets due to Social Security, workers' compensation; failure to comply with program eligibility rules; gainful employment if receiving total and permanent disability related benefits; termination of the plan; tax levy; any benefit plan overpayments due to any reason.

- Supplements are not payable to you if you (1) retire voluntarily as early as age 55 and prior to age 60 and the sum of your age and years of credited service is less than 85, or (2) are discharged.

- If the total of monthly benefits under Part A and the Part B supplementary benefit exceed 70% of your final monthly base salary, the monthly Part A early retirement or interim supplement will be reduced to the extent required so that such benefits would equal 70% of the final base salary.

- Supplements are not applicable to you if you were hired on or after January 1, 1988.

- If you retire voluntarily and become eligible for Social Security Disability Insurance Benefits (SSDIB), your monthly supplement will be reduced by the temporary benefit amount in effect at the date of your SSDIB award.

- Supplements are only payable if you retire within five years of your last day worked for General Motors.

GMAC Demand Notes

GMAC Demand Notes is designed to offer eligible GM family members a convenient means of investing funds directly with GMAC. Demand Notes are unsecured debt obligations of GMAC. Demand Notes is neither a money market fund nor a bank account and is not FDIC insured.

Eligibility

As a GM retiree or surviving spouse, you are eligible to participate in GMAC Demand Notes. Your family members and friends are also eligible to participate in GMAC Demand Notes.

- **Low initial investment**
  You may open a GMAC Demand Notes account with as little as $1,000. Additional investments of $50 or more may be made at any time.

- **Special benefit for GM Retirees**
  You can begin earning interest immediately on your pension and Social Security checks by having them invested directly into Demand Notes.

- **Easy, convenient access to your money**
  You may access your Demand Notes investment at any time using one of several convenient redemption options, including free check-writing privileges ($250 minimum) and redemptions by telephone.

- **Interest rate**
  The interest you earn on your Demand Note is compounded daily and reinvested automatically in your Note at the end of the month. The Demand Notes rate is reviewed on a weekly basis. For current rate information call 1-800-426-8323.

- **Investor services**
  You will receive periodic statements showing a summary of your Demand Notes investments and redemptions, interest earned and the interest rates applicable during that period. As a Demand Note investor, you also will have 24-hour, toll-free access to complete information about the status of your investment and current interest rate by calling 1-800-684-8823. You can also access your account information online at www.demandnotes.com.

Additional Information

The money you invest in Demand Notes is principally used by GMAC to provide a wide variety of automotive financial services to automobile dealers and their customers. GMAC's business lines also include insurance, mortgage and commercial finance.

Enrollment Information

GMAC DEMAND NOTES ARE OFFERED IN THE U.S. BY PROSPECTUS ONLY. You can obtain a Prospectus by calling 1-888-271-4066 or by visiting the GMAC Demand Notes website: www.demandnotes.com.

Your Health Care Benefits

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Your Health Care Benefits

The General Motors Salaried Health Care Program (the Program) provides comprehensive coverage for you and your eligible dependents for a wide range of health care services and expenses including acute care services (such as surgery and hospitalizations) and preventive care (such as physicals and physician office visits). There also are components covering long-term and custodial care needs. The Program helps protect you from catastrophic medical costs while allowing flexibility in the way you plan for your health care expenses.

The specific provisions of the Salaried Health Care Program, the range of covered services, eligibility rules and so forth may be amended, modified, suspended, increased, decreased or terminated by General Motors from time to time through the years. Additionally, while coverages provided under this Program are very broad and comprehensive, the Program does not cover all health care services and expenses under all circumstances, nor is it intended to do so. You should seek guidance from your health care carrier (for example, Blue Cross & Blue Shield) if you have questions about whether a particular health care service or expense is covered under the Program. The following information is based upon the Program provisions as of January 2005, unless otherwise noted.

Eligibility for Coverage...

You

Generally, under current provisions, your participation in the Salaried Health Care Program can be continued in retirement. However, you are required to pay the full monthly cost of any continuing coverage if you were an employee:

- Whose continuous service with the Corporation commenced on or after January 1, 1993;
- Who retired on or after February 1, 1989 with less than 10 years of credited service under the General Motors Retirement Program for Salaried Employees;
- Who (a) retired prior to February 1, 1989, (b) was age 60 or older but less than age 65, and (c) retired without being eligible for retirement benefits; or
- Who retired voluntarily at or after age 55 and prior to age 60 when your combined years of age and credited service total less than 85. If you were hired prior to January 1, 1988 and retire voluntarily with 30 or more years of credited service, you ***are*** eligible for Corporation contributions.

If you are eligible only for a deferred retirement benefit, you are NOT eligible for any General Motors Salaried Health Care Program coverage.

Disqualification, Ineligibility, Denial, Loss, Forfeiture, Suspension, Offset, Reduction or Recovery of Benefits

Generally, your eligibility for coverage ceases at the end of the month you are last in active service. Any continuation beyond that point is based upon your retirement status. Your continuation opportunities are described in this section, entitled “Eligibility for Coverage…”

Benefit payments are subject to Coordination of Benefits. If another plan or program is primary, the claim should be filed first with the primary plan or carrier.

For services that require predetermination, benefit payments may be reduced if you fail to call and receive authorization.

If any benefits are paid for non-covered services or on behalf of ineligible dependents, you will be responsible for repaying the overpayment. If you should fail to repay the overpayment promptly, the Health Care Program will deduct the amount from your other benefits or compensation, or may recover the overpayment by other legal means.

If a Medicare-eligible surviving spouse fails to enroll in Medicare Part B, the surviving spouse will not be eligible for corporation contributions for health care coverage.

Your Dependents

Some of your dependent family members may be enrolled for coverage with Corporation contributions while for others you must pay the full cost of coverage.

Family members enrolled prior to your retirement, or before July 1, 1988, may be eligible for coverage with Corporation contributions.

They include:

- Your spouse;
- Your natural or adopted children;
- Your current spouse’s natural or adopted children;
- Your same-sex domestic partner (if enrolled prior to retirement); and
- Your same-sex domestic partner’s children (if enrolled prior to retirement).

For additional information concerning same-sex domestic partner eligibility, contact the GM Benefits & Services Center at 1-800-489-4646.

You should note that, since July 1, 1988, a spouse or child acquired after retirement can be enrolled only as a sponsored dependent, as described later in this section. Same-sex domestic partners and their children acquired after retirement are not eligible for coverage.

To be eligible for Program coverage with Corporation contributions, children must meet certain tests. These tests include:

- ***Relationship:*** The children must be yours or your current spouse's by birth or legal adoption.

- ***Age:*** The children must not have reached the end of the calendar year in which they turn age 19, except for two cases.

  The first is if the children are ***full-time students*** for at least one full school term during the calendar year, in which case they remain eligible for such year(s), ***but not beyond the end of the calendar year in which they turn age 25***. Such children, age 24 or older must qualify as dependents under Section 152 of the Internal Revenue Code.

  The second exception is the case of ***totally and permanently disabled (T&PD) children***. T&PD children may have coverage continued if they continuously meet the Salaried Health Care Program's definition of T&PD status (i.e., having any medically determinable physical or mental condition that prevents a child from engaging in substantial gainful activity and that can be expected to result in death or be of long-continued or indefinite duration) and continue to meet all other applicable eligibility requirements.

- ***Marital status:*** The children must not be married.

- ***Residency:*** The children must reside with ***you*** (children temporarily away from home while attending school full time meet this test) or ***you*** must have legal responsibility for the provision of health care coverage. If you are ordered to provide coverage for your children pursuant to a divorce decree, court order, paternity order or a Qualified Medical Child Support Order (QMCSO) as defined by the Omnibus Budget Reconciliation Act of 1993 (OBRA-93), you may be able to satisfy the residency test for children that do not reside with you.

Sponsored Dependents

You also may be able to enroll certain individuals for limited GM medical coverage as Sponsored Dependents if you are ***able to, and do, legally claim exemptions for them on your federal income tax return.*** You pay the full cost of such coverage. The following individuals may be enrolled for Sponsored Dependent coverage:

- Your child or your current spouse's child who:
  - — is single,
  - — lives with you, and
  - — does not satisfy the age test;

- A minor child living with you and for whom either you or your current spouse is the court-appointed guardian because both natural parents of the minor child are deceased;

- A minor child who lives with you and who is the child of your enrolled dependent child;

- One or both of your parents or your current spouse's parents; or

- A spouse and/or child acquired after retirement.

Before becoming eligible for coverage, sponsored dependents who are not citizens of the United States must reside in the United States for one full year and must be legally entitled to remain in the United States indefinitely. The medical coverage available to

Sponsored Dependents is the same option you choose for yourself. Each Sponsored Dependent has his or her own set of contributions, deductibles, copayments, and out-of-pocket maximums, if applicable. Coverage is effective the first of the month following receipt of a completed application and any necessary supporting documentation.

You may not purchase dental, vision or Extended Care Coverage (ECC) for Sponsored Dependents.

Medical Plan

Periodically, retirees and surviving spouses will be provided an opportunity to elect coverages through the medical plan options available under the Program. Such elections also may include a choice among dental options.

The specific choices available will depend on your status, the availability of approved options in your geographic area, and your (and your eligible dependents') Medicare status. Additionally, you may be required to make monthly contributions for coverages, as determined annually, according to your status, enrollment classification, option elected, the type and number of dependents enrolled, and your dependents' Medicare status.

You may elect from among four medical plan options and certain dental plan options to the extent such options are available in your area. From time to time, the types of available options may change. The current Medical Plan options are as follows:

- The Basic Medical Plan (BMP) option;
- The Enhanced Medical Plan (EMP) option;
- The Preferred Provider Organization (PPO) option; and
- The Health Maintenance Organization (HMO) option.

These options are designed to deliver quality care on a cost-effective basis. Descriptive materials concerning benefits provided under each option are available from the GM Benefits & Services Center. In general, covered expenses and major limitations and exclusions are summarized below. ***This is a general description only and the provisions of the Salaried Health Care Program control your eligibility for coverage and specific benefits.*** Furthermore, each HMO has its own rules which should be obtained from the HMO. A glossary of terms is provided at the end of the handbook. Also provided on page 25 is a chart intended as an at-a-glance resource.

Under the Basic Medical Plan, the Enhanced Medical Plan and the Preferred Provider Organization, selected carriers handle certain administration and claims processing for the GM programs. Under the Health Maintenance Organization option, coverages are provided by HMOs for which General Motors contributes for the premiums. The individual HMOs are solely responsible for financing, administration, medical policy, claims processing, and appeal procedures.

Three features — Care Management, Disease Management and Centers of Excellence — are applicable for salaried, non-Medicare retirees and eligible dependents in the Basic Medical Plan, the Enhanced Medical Plan and Preferred Provider Organization options.

The **Care Management** feature requires advance review of any hospital stay, surgery, skilled nursing facility admission or home health care visit. Emergency admissions must be reported within 48 hours of inpatient admission. Keep in mind that certain invasive tests and injections are considered surgery. If in doubt about the nature of the proposed treatment, you should call SHPS (formerly Health International). Nurses and board-certified physicians from our Care Management administrator, SHPS, advise, educate and present alternatives that help enable patients to make informed decisions about the treatment that's best for them. **You are responsible for assuring that SHPS is**

called regarding procedures that require predetermination. If a procedure is determined not to be covered under the Program, you and your provider will receive communication regarding its non-covered status.

If you do not call, or if you proceed with services that are considered medically inappropriate, you will be responsible for up to an additional $200 per occurrence for services provided. These amounts (up to $600 per year) are in addition to any normal deductibles and copayments, and will not be applied to your out-of-pocket maximum.

Services determined not to be medically necessary are not covered. Predetermination is not a guarantee of benefit payment. To be covered, the service must meet all terms and conditions of the Program.

The **Disease Management** feature is a confidential, voluntary resource if you have a serious chronic condition, such as asthma, diabetes or heart disease. Medical professionals who specialize in these conditions work with you and your doctor to develop a personalized coordinated plan of care with the goal of increasing the likelihood you receive appropriate, evidence-based, high-quality care.

Centers of Excellence is a confidential, voluntary resource that provides you with information about and access to doctors, hospitals and health centers that are nationally recognized for improved outcomes in treating specific conditions. Financial assistance may also be provided if you and a family member need to travel to a Center over 100 miles from your home. When travel to a Center of Excellence is approved by Health International, certain travel expenses of up to $7,500 may be reimbursed through procedures that have been established by the administrator.

Questions regarding the Care Management, Disease Management and Centers of Excellence features may be directed to SHPS (formerly Health International) at 1-877-299-4635.

Basic Medical Plan (BMP)

If you enroll in the BMP option for core coverages, currently you will not be required to make a monthly contribution. However, you will be required to share a part of the expense of covered services.

- Annual $900 individual and $1,800 family deductibles will be applied to covered services (other than certain screening tests/examinations, durable medical equipment and prosthetic and orthotic appliances, prescription drugs, mental health, substance abuse, and extended care services, as discussed in later sections). Only the reasonable and customary charges for covered services can be counted toward meeting the deductibles. Each covered individual can contribute only a maximum of $900 toward satisfying the family deductible.

- After the annual deductible is met, you will be responsible for a 25% copayment for most covered services, until your annual out-of-pocket expense for such copayment equals a maximum of $1,600 for an individual or $3,200 for a family. Your maximum annual out-of-pocket expense for the deductible and copayment for covered services is limited to $2,500 ($900 individual deductible plus $1,600 copayment) for an individual and $5,000 ($1,800 family deductible plus $3,200 copayment) for a family.

  After your maximum annual out-of-pocket expense is reached, expenses for any remaining covered services will be paid at 100% of the reasonable and customary amount for the rest of the year.

- Prescription drug, mental health, substance abuse, and extended care coverages are not subject to the deductibles and copayments noted above. Charges incurred for prescription drug, mental health, substance abuse treatment, and extended care services will not be counted toward satisfying the deductible, co-payment, or out-of-pocket maximum.

For non-Medicare retirees, Care Management, Disease Management and Centers of Excellence features apply to the BMP option.

Enhanced Medical Plan (EMP)

The features of the EMP option are the same as those of the BMP option previously described except:

- A monthly contribution is required for core coverages;

- The annual deductible amounts are $450 and $900 for an individual and a family respectively;

- The copayment rate for expenses incurred above the deductible is 20% up to a maximum annual amount of $1,050 for an individual and $2,100 for a family; and

- The total annual out-of-pocket maximum for deductible and copayments for covered services is $1,500 and $3,000 for an individual and a family respectively.

For non-Medicare retirees, Care Management, Disease Management and Center of Excellence features apply to the EMP option.

Preferred Provider Organization (PPO)

Under this health care arrangement, selected physicians, hospitals, and other health care providers in a geographic area are pooled together as a network to provide services to you and your family. PPOs are offered based on your address of record. Provider directories are available, without charge, from your local carrier on-line and/or by calling their toll-free number.

For non-Medicare retirees, Care Management, Disease Management and Centers of Excellence features apply to the PPO option.

The features of the PPO option are the same as those of the BMP option previously described except:

- You may be required to pay a monthly contribution for enrollment in the PPO option;
- The annual deductible amounts are $300 and $600 for an individual and a family, respectively;
- When PPO network providers are used and all PPO network rules (e.g., required referrals) are followed, core coverages, (other than certain screening tests/examinations, prescription drugs, mental health, substance abuse, and extended care services) are subject to a 10% copayment, up to a calendar year maximum out-of-pocket cost for covered services of $1,300 for an individual and $2,600 for a family;
- If you choose to go to a non-PPO network provider (unless referred by a PPO panel provider or in the event of an emergency), payment for covered services will be 70% of the PPO's level of payment for the same service or, if less, 70% of the actual charge. You will be responsible for the difference between the PPO's payment and the non-panel provider's charge. The amount of your liability will **not** be applied to the $1,300 individual or $2,600 family out-of-pocket maximum.

Health Maintenance Organization (HMO)

Health Maintenance Organizations (HMOs) are local health care delivery systems. HMO coverage differs from the BMP and EMP options in that you must receive services from HMO providers for the services to be covered. Unlike the PPO option, non-emergency services obtained from providers outside of the HMO panel are ***not*** covered at all unless the primary care physician makes the referral or the HMO authorizes treatment.

HMOs have monitoring systems to assess quality of care, necessity of treatment, and appropriateness of inpatient hospital stays. The coverage varies among individual HMOs, but all HMOs include certain preventive and routine care services such as physical exams, office visits and immunizations. Generally, such care is provided at lower or no cost to you. A summary of the coverages provided by each HMO is located at gmbenefits.com.

If you are enrolled in the HMO option, all of your core coverages are provided by the HMO except Extended Care Coverage. ***Coverage for specific services may vary from that provided under the BMP, EMP, and PPO options*****.** The applicable information in the certificate you receive from the HMO is incorporated in this Summary Plan Description handbook by reference. It contains specific information about any cost-sharing provisions, including deductibles, coinsurance, and copayment amounts for which the participant will be responsible; any annual or lifetime caps or other limits on benefits under the plan; the extent to which preventive services are covered under the plan; whether, and under what circumstances, existing and new drugs are covered under the plan; whether and under what circumstances, coverage is provided for medical tests, devices and procedures; provisions governing the use of network providers, the composition of the provider network, and whether, and under what circumstances, coverage is provided for out-of-network services; any conditions or limits for selection of primary care providers or providers of specialty medical care; any conditions or limits applicable to obtaining emergency medical care; and any provisions requiring preauthorizations or utilization review as a condition to obtaining a benefit or service under the plan. Provider directories are available, without charge, at the HMO's website, or by calling their toll-free number. It is important to review the HMO certificate carefully to become familiar with the scope and level of benefits that are available through a particular HMO.

HMOs are offered based on your address of record. You should contact the GM Benefits & Services Center to obtain information regarding any HMO available to you. Additional literature can be obtained by

contacting an HMO and requesting the membership handbook that describes its benefits and the provider directory that lists the doctors, hospitals, laboratories, pharmacies, and other providers that participate in that HMO. If you are considering enrollment in an HMO, you should carefully review the HMO's provider directory or contact the HMO to understand provider availability in your area.

The individual HMOs are solely responsible for administration, claims processing and appeal procedures.

Availability of PPO and HMO Options

The options available to you are determined by your address of record. In some geographic areas, a PPO or HMO may not be offered. In addition, the PPO option and certain HMOs are not currently available to retirees and surviving spouses enrolled in Medicare. Periodically, you will be provided an opportunity to change options if more than one is available.

If you or one of your dependents has Medicare, only those plans accepting Medicare eligible participants will be offered. If, after electing a PPO or HMO closed to Medicare enrollees, you or one of your dependents become enrolled in Medicare, you will have the opportunity to change your medical plan enrollment. Should this occur, contact the GM Benefits & Services Center.

BMP, EMP, PPO and HMO At-A-Glance

	BMP (1)	EMP (1)	PPO		HMO
			In-Network (1)	Out-Of-Network (2)	
Monthly contributions	None	Yes	Varies	Varies	Varies
Annual deductible:			$300		
Individual	$900	$450			None
Family	$1,800	$900	$600 (Combined in and out of Network)		None
Copayment: (3)					
Plan pays	75%	80%	90%	70% PPO Fee	Varies
You pay	25%	20%	10%	The balance	Varies
Out-of-pocket maximum: (3)					
Individual	$2,500	$1,500	$1,300	Not applied to	None
Family	$5,000	$3,000	$2,600	maximum	None

(1) Annual deductibles, copayments, and out-of-pocket maximums are calculated on the basis of "Reasonable and Customary" (R&C) charges as determined by the carrier. For PPOs, and for BMP and EMP in the case of those carriers with "participating" or approved provider arrangements, it is the amount the participating/approved provider has agreed to accept for covered services.

(2) Except in the case of a bona fide medical emergency, if you use a non-PPO provider without the proper preauthorization, the plan will pay 70% of the lesser of the charge or the PPO's fee schedule and you will pay the rest.

*(3) Deductibles, copayments, and out-of-pocket maximums apply only to covered hospital, surgical, and medical services. They do not include mental health/substance abuse coverage or prescription drug coverage. PPO out-of-network copayments will **not** be applied to PPO out-of-pocket maximums.*

Medical Plan Coverages

The various medical plan coverages described in this section apply to the BMP, EMP, and PPO. As previously noted, medical coverages available under HMO options may vary from those described below.

Hospital

What Is Covered

In general, for an inpatient stay to be eligible for plan coverage, it must be: (1) medically necessary, (2) prescribed by your doctor, and (3) "predetermined" by the Utilization Review Organization, SHPS (formerly Health International), as to the setting and length of stay. ***(Note: Predetermination is not a guarantee of payment. In addition, benefit payment can be severely limited for Blue Cross & Blue Shield enrollees who receive non-emergency services at a non-participating hospital. You should call your medical carrier to verify your eligibility for benefit payment.)***

Your doctor may order surgery, tests, or treatment that do not require an overnight stay. When you or a dependent receive covered services from an outpatient department of a hospital, the hospital's facility charges are generally covered on the same basis as inpatient care. Facility charges also may be covered for services performed in an ***approved*** free-standing ambulatory surgery facility. Predetermination is required for outpatient surgery before the procedure is performed. You should consult your medical plan carrier to determine the approval status of any particular FASC.

Facility charges covered under hospital coverage (maximum of 365 days per "benefit period," 45 days in the case of tuberculosis) include, but are not necessarily limited to:

- Semiprivate room, general nursing services, meals and special diets, and service in a special care unit;
- Private room accommodations, if medically necessary;
- Use of operating rooms;
- Anesthesia when administered by an employee of the hospital and anesthesia supplies, gases, and use of equipment;
- Laboratory and pathology examinations under the direction of the hospital's pathologist;
- Chemotherapy (chemotherapeutics, antineoplastic agents, and select ancillary drugs and administration) for the treatment of malignant diseases by chemical antineoplastic agents except when treatment is (1) research, (2) investigational, or (3) experimental in nature;
- Physical, functional occupational, and speech therapy;
- Drugs, biologicals, solutions, oxygen, and other supplies and equipment used in treatment while in the hospital;
- Blood services, including transfusions of whole blood and pack red blood cells (if not replaced);
- Maternity care and routine nursery care. Generally, under federal law, benefits for any hospital length of stay in connection with childbirth for the mother or newborn child may not be restricted to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a caesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization for prescribing a length of stay not in excess of the above periods;

- Hemodialysis when provided by a hospital qualified to provide hemodialysis treatment and that has a hemodialysis program approved by the carrier;
- Necessary and appropriate x-rays;
- Pulmonary function evaluation;
- Hyperbaric oxygenation provided in the hospital outpatient setting for patients with emergent conditions. Such as cyanide poisoning, acute carbon monoxide intoxication and decompression illness;
- Tissue storage bank costs (e.g., skin banks and bone banks) for inpatients only; and
- Outpatient emergency room services and observation care (see the glossary for definition and further description of terms and conditions).

What Is Not Covered — Limitations and Exclusions

Limitations and exclusions to the hospital coverage include, but are not necessarily limited to the items listed below:

- Drugs, biologicals and solutions — beyond the extent they are used in connection with the inpatient or outpatient service;
- Chemotherapy done on a research, investigational or experimental basis (as determined by the carrier);
- Outpatient treatment of chronic conditions that require repeated hospital visits (except hemodialysis and IV infusion therapy);
- Follow-up care in an emergency room for treatment received initially in an emergency room (follow-up should be done in a physician's office to avoid facility charges);
- Skin bank, bone bank, and other tissue bank services for outpatients (except for certain specified procedures);
- Hospital admissions and services beyond the period that is medically necessary for the proper care and treatment of the patient, or in excess of the maximum benefit period (see glossary for definition) or inconsistent with other applicable Program provisions;
- Hospital services related to domiciliary, custodial, convalescent, nursing home, or rest care;
- Hospital services consisting principally of dental treatment or extraction of teeth (except when either multiple extractions or the removal of one or more unerupted teeth is performed under general anesthesia ***and*** a concurrent hazardous medical condition exists);
- Inpatient hospital services when the care received consists principally of observation or diagnostic evaluations, inpatient physical, functional occupational, or speech therapy, x-ray examinations, laboratory examinations, electrocardiography or basal metabolism tests, ultrasound studies, nuclear medicine studies, weight reduction by diet control with or without medication or environmental control;
- Facility charges for care received in an urgent care center;
- Facility charges for care received in a freestanding ambulatory surgery center, unless such center meets Program standards and is approved by the carrier; and
- Facility charges related to refractive eye surgery (e.g., radial keratotomy, corneal sculpting, or similar surgical procedures to correct vision), sterilization reversals, or non-covered plastic, cosmetic, or reconstructive surgery;
- Reimbursement limits of:
  — up to $250 per day for room, board, and all covered inpatient services in a **non-participating** non-psychiatric

hospital, and full coverage for the first five days of emergency admissions;
— up to **$35 per condition** for covered **outpatient services** received **at a non-participating** non-psychiatric **hospital** (services may be covered at a participating hospital rate in some cases of emergency).

Skilled Nursing Facility

Services received from skilled nursing facilities licensed to provide such care may be covered under your GM medical plan. ***When such services are recommended, they must be predetermined prior to the admission, to determine if such services are covered by the Program and to ensure that the intended provider of such services is approved by the carrier. You should call or ask your doctor, the hospital and/or discharge planning staff or the skilled nursing facility staff to make the call to predetermine these services. (Note: Predetermination is not a guarantee of payment.)***

The Care Management Administrator can also determine whether the patient is a candidate for case management and work with the Extended Care Coverage (ECC) carrier and the DME and P&O Network in appropriate cases.

What Is Covered

Two days of inpatient skilled nursing facility care are available for each remaining day of inpatient hospital care within the benefit period (see glossary for definition), up to a maximum of 730 days for each continuous period of confinement. Each day of inpatient hospital care within a benefit period reduces by two the number of days of care available for skilled nursing facility services. The use of skilled nursing facility days does not reduce the number of days of inpatient hospital care available.

For skilled nursing facility care to be covered it must be:

- Prescribed by a physician;
- Medically necessary based on the severity of illness/injury and intensity of the service;
- Received from a carrier-approved skilled nursing care facility; and
- Provided and billed by the facility.

Services provided under skilled nursing facility coverage include, but are not necessarily limited to, the items listed below:

- Semiprivate room and board and general nursing services;
- Meals and special diets;
- Use of special treatment rooms;
- Routine laboratory exams;
- Physical, functional occupational, and speech therapy, when medically necessary;
- Drugs, biologicals, solutions, oxygen and other supplies used while in the facility; and
- Durable Medical Equipment.

What Is Not Covered

Services not covered under the skilled nursing facility coverage include, but are not necessarily limited to, the items listed below:

- Care that is principally custodial or domiciliary in nature (although coverage may be available under Extended Care coverage); and
- Treatment for tuberculosis or substance abuse.

Physical, Functional Occupational and Speech Therapy; and Cardiac Rehabilitation

When you or a family member require certain therapy to restore or improve musculoskeletal, speech, or cardiac performance, your health care program may provide coverage to help you meet these needs.

Outpatient services must be (1) approved by the carrier, (2) prescribed by the physician in charge of the case, (3) provided or supervised by a physician (other than a limited-practice physician) or by a registered and licensed physical, occupational, or speech therapist for the specific therapy prescribed, and (4) billed by a physician (other than a limited-practice physician), or a hospital, or a freestanding outpatient physical therapy facility, home health care agency, skilled nursing facility, or independent therapist approved by the carrier.

What Is Covered

Services provided under physical, functional occupational, speech therapy, and cardiac rehabilitation coverage include, but are not necessarily limited to, the items below:

- Medically necessary physical, functional occupational, speech therapy, and cardiac rehabilitation:
  - During a covered admission to a hospital or skilled nursing facility for the treatment of the condition for which the patient is admitted. These services normally are billed by the hospital or skilled nursing facility;
  - Care prescribed and received through an approved rehabilitation center that meets Program standards;

- Physical, functional occupational, and speech therapy provided through an approved home health care agency;

- Outpatient physical and functional occupational therapy to restore or improve musculoskeletal function;

- Restorative speech therapy on an outpatient basis when related to the treatment of an organic medical condition or to the immediate post-operative or convalescent state of the enrollee's illness, subject to certain limitations;

- Cardiac rehabilitation on an outpatient basis provided through a hospital or performed or supervised and billed by a physician (limited to services provided during the six-month period immediately following acute myocardial infarction, initial diagnosis of angina pectoris, or certain heart surgeries); and

What Is Not Covered

Services not covered under the physical, functional occupational, and speech therapy and cardiac rehabilitation provisions include, but are not necessarily limited to, the following:

- Speech therapy for:
  - Educational learning disabilities;
  - Deviant swallow or tongue thrust;
  - Mild developmental speech or language disorders;
  - Congenital deafness;
  - Elimination of a lisp, or similar defect in articulation;
  - Improving speech that is not fully developed; or
  - Long-standing, chronic conditions or inherited speech abnormalities
    - When the patient is diagnosed as having a severe communication deficit as defined by Program standards; and when speech therapy is not available through other public agencies (e.g., state or school);

- Physical and functional occupational therapy when:
  - The condition is not expected to improve in a reasonable and generally predictable period of time;
  - Improvement does not occur, as documented in the patient's record on a periodic basis; or
  - Progress is no longer being made or the previous level of function has been restored;

- Physical and/or functional occupational therapy provided solely to maintain musculoskeletal function;
- Inpatient admissions which are principally for physical, functional occupational, and/or speech therapy or cardiac rehabilitation;
- Manipulation, adjustment, or massage of the musculoskeletal system;
- Vision therapy or training;
- Cognitive rehabilitation, (including, but not limited to, vocational rehabilitation, recreational therapy, or learning exercises);
- Day, night, or residential rehabilitation programs;
- Services which could be performed by an untrained, unlicensed person, by the enrollee, or by a member of the enrollee's family; and
- Physical and/or functional occupational therapy for first and second degree burns.

Home Health Care

When a patient no longer requires constant care, home health care services of a part-time or intermittent nature may be prescribed by the doctor.

- ***When home health care services are recommended they must be predetermined prior to incurring expenses, to determine if such services are covered by the Program and to ensure that the intended provider of such services is approved by the carrier*.** Health International can also determine whether the patient is a candidate for special Program components (such as case management) and interface with the Extended Care Coverage (ECC) carrier and the DME/P&O network in appropriate cases (Note: Predetermination is not a guarantee of payment);
- Coverage for home health care services is available only when the patient is essentially homebound, and the services are medically necessary.

What Is Covered

When home health care is medically necessary and appropriate, the following services are ***covered, if they are provided on a part-time and intermittent basis*** during a home health care visit and billed by a home health care agency approved by the carrier. Services provided under home health care coverage include, but are not necessarily limited to, the items below:

- General nursing services;
- Physical therapy and speech therapy;
- Social service guidance, dietary guidance, and functional occupational therapy; and
- Home health aide services (if provided in conjunction with general nursing services, or physical or speech therapy services) by an approved health care agency.

The following are covered when provided and billed by an approved provider:

- Laboratory tests;
- Drugs, biologicals, solutions; and
- Medical supplies ordered by the physician and necessary for the home medical regimen.

What Is Not Covered

Services not covered under the home health care provisions include, but are not necessarily limited to, the following:

- Supplies such as elastic stockings, personal comfort or personal hygiene items or equipment, or supplies and appliances that may be covered under Durable Medical Equipment (DME) or Prosthetic and Orthotic Appliance (P&O) provisions;

- Physician services, private duty nursing, or housekeeping services;
- Skilled nursing services and home health aide visits when the care exceeds the part-time or intermittent levels;
- Home uterine monitoring;
- Travel time; and
- Services for which the cost would exceed the daily cost for similar care in a skilled nursing facility.

Surgical and Medical

You are eligible for benefits for expenses incurred for covered surgical and medical services when such services are approved by the carrier and are medically necessary. Your carrier will pay benefits for covered services based on a fee schedule, capitation schedule or its determination of reasonable and customary charges.

Surgical procedures, including certain tests, injections, and other services classified by the American Medical Association as surgery, must be predetermined. If you have questions concerning whether a procedure is considered surgery, you should contact Health International. (Note: Predetermination is not a guarantee of payment.)

What Is Covered

Services covered under surgical and medical provisions include, but are not necessarily limited to, the items below.

- Certain surgical services consisting of generally accepted operating and cutting procedures for the necessary diagnosis and treatment of disease, injuries, fractures, or dislocations, including medically recognized human organ transplants, laser surgery if the alternative cutting procedure is covered, and voluntary sterilizations (but not reversals);
- Certain plastic and reconstructive surgery, such as correction of deformities following cancer surgery or accidental injuries;

  In the case of a participant or beneficiary who undergoes a mastectomy and who elects breast reconstruction in connection with the mastectomy, under federal law, coverage must include:
  - reconstruction of the breast on which the mastectomy has been performed;
  - surgery and reconstruction of the other breast to produce a symmetrical appearance; and
  - prostheses and physical complications of all stages of mastectomy, including lymphedemas,

  in a manner determined in consultation with the attending physician and the patient.
- Certain dental surgery (e.g., multiple extractions or removal of one or more unerupted teeth) is covered ***when performed in the hospital (inpatient or outpatient setting) or at a freestanding ambulatory surgical center, but only when a concurrent hazardous condition requiring such hospitalization exists***;
- Hemodialysis;
- Anesthesia (by other than the operating physician), including the administration of anesthesia by a lay or nurse anesthetist in the employ of the physician who authorizes the services and who is available for immediate attendance;
- Medically necessary technical surgical assistance, (i.e., services of a physician or a physician assistant who actively assists the operating physician) when the services of interns, residents, or house officers are not available. In order for technical surgical assistance performed by a physician assistant to be covered, the physician assistant must be legally qualified and registered, certified and/or licensed, as applicable, to perform these

health care services. The physician assistant must meet Program standards and be approved by the carrier. Reimbursement for technical surgical assistance services performed by a physician assistant will be made to the employer of the physician assistant;

- Maternity care, including prenatal and postnatal care;
- Obstetrical services (received in a hospital or birthing center affiliated with a hospital) provided by a certified nurse midwife. Coverage is limited to basic antepartum care, normal vaginal deliveries, and postpartum care;
- Consultations when requested by the physician in charge;
- Chemotherapy for malignant conditions, both inpatient and outpatient — excluding research, investigational or experimental services;
- Therapeutic radiology and certain diagnostic radiology services;
- Laboratory services;
- Certain services related to contraception;
- Physician medical visits in the home, doctor's office, hospital or skilled nursing facility for:
  - — Inpatient medical care when provided by the physician in charge of the case;
  - — Treatment rendered in or at a hospital when provided by a physician who is not an employee of the hospital;
  - — Well child(ren) care for enrollees six years of age or younger; and
  - — One physical examination per calendar year for enrollees over six years of age;
- Certain immunizations and injections;
- Foot care for treatment of injuries and/or infections; and
- Screening examinations.
  (Note: Certain screening exams will not be subject to the deductible or copayment requirements.)

What Is Not Covered

Services not covered under the surgical and medical provisions include, but are not necessarily limited to:

- Physician medical visits for the types of care listed below (although some may be covered under other provisions of the Program):
  - — Mental health or substance abuse treatment;
  - — Routine eye examinations;
  - — Insurance, employment, and premarital examinations;
  - — Manipulation, adjustment, or massage of the musculoskeletal system;
  - — Allergy testing, treatment, or injections;
  - — Weight control;
  - — Acupuncture; or
  - — Services provided by non-physician practitioners (e.g., physician assistants (except as provided above), Christian Science practitioners);
- Dental services including extraction of teeth except as provided for earlier;
- Examinations and tests in connection with research studies, paternity determinations, weight control, autopsies, etc.;
- Charges for stand-by physicians or similar charges where no service is actually performed;
- Services relating to refractive eye surgery (e.g., radial keratotomy, corneal sculpting, or similar surgical procedures to correct

vision);

- Growth factor treatment for wound care; and
- Thermography.

Ambulance Service

GM's medical plan provides you with ambulance service coverage when the following three conditions are met:

- Ambulance services must be medically necessary (ambulance services are not medically necessary if any other means of transportation could be used without endangering the patient's health);
- Services are provided by an approved, licensed ambulance operation; and
- A physician prescribes the services that necessitate use of an ambulance.

What Is Covered

Services covered under the ambulance service provisions include, but are not necessarily limited to, the following:

- Basic life support services that consist of services that provide for the initial stabilization and transport of a patient;
- Advanced life support services (defined as acute emergency treatment procedures with physician involvement);
- Mileage charges while the patient occupies the ambulance;
- Waiting time involved in round-trip transport of an enrollee from a hospital to another treatment site and return to the same hospital;
- Transportation to the nearest medical facility qualified to provide treatment; transportation to other than the nearest, qualified treatment facility will only be covered in an amount equal to that for transportation to the nearest facility; and
- Air and boat ambulance transportation is subject to individual review and, unless the services of air or boat ambulance are determined to be medically necessary, will only be covered in an amount equal to that for ground transportation, assuming ground ambulance services were medically necessary.

What Is Not Covered

Services not covered under the ambulance provisions include, but are not necessarily limited to, the following:

- Transportation in a vehicle not qualified as an ambulance;
- Transportation for the convenience of you, your family, or your physician;
- Services rendered by providers whose fee is in the form of voluntary donation, for example, fire departments or rescue squads;
- Transfers not medically necessary;
- Services billed by physicians or other independent health care providers for care rendered to enrollees transported by ambulance;
- Services when you are not actually transported while under care;
- Services payable through an existing arrangement to transfer patients where no additional charge is usually made, whether or not such services were immediately available;
- Services that are covered as a component of the basic or advanced life support services such as:
  - Use of specific equipment or devices;
  - Gases, fluids, medications, dressings, or other supplies;
  - First aid, splinting, or any emergency medical services or personal service procedures; and
  - Vehicle operators, attendants, or other personnel.

Prescription Drugs

Prescription drug coverage is delivered through retail pharmacies participating in the National Managed Pharmacy Network. The National Managed Pharmacy Network pharmacies provide prescription drug services that meet high quality standards. Generally, a participating pharmacy will be located within three miles of your residence. Medco Health is the carrier for this coverage.

When you use a network pharmacy, the copayment for generic drugs is $5. For preferred brand-name drugs, the copayment is 25% per prescription or refill with a minimum of $15 and a maximum of $25. For non-preferred brand-name drugs, the copayment is $50. For drugs that cost less than the applicable copayment, you will be charged the network cost of the drug. A listing of preferred brand-name drugs can be obtained by calling Medco customer service at 1-800-464-4679 or accessing the Medco website www.medco.com.

Locating a Network Pharmacy

There are over 40,000 network pharmacies nationwide. You may call 1-800-464-4679 to locate a network pharmacy anywhere in the country. When you are traveling out of your home area, or if you have dependents living away from home, the customer service representative on the toll-free line will assist you in locating the nearest network pharmacy.

Using a Non-Network Pharmacy

If you have a prescription filled at a non-network pharmacy, you will pay the pharmacist the full cost of the prescription. When you submit a claim form to Medco Health, you will be reimbursed for 75% of the reasonable and customary charge after your copayment has been deducted. Claim forms may be obtained on-line at www.medco.com or by calling Customer Service: 1-800-464-4679.

In the event of any emergency, or if you are traveling and cannot locate or access a network pharmacy, your non-network claim for covered prescriptions will be reimbursed at 100% of the reasonable and customary charge after your copayment has been deducted.

Mail Order Prescription Drug (MOPD) Option

If you are taking any medications on a regular basis, you may be able to save money by purchasing your prescription through the mail order option, sometimes referred to as home delivery.

When you order your prescriptions by mail, you will not have to submit claim forms or wait for reimbursement. Your medication is delivered to your home, postage-paid, within 14 days from the date you mail your prescription. You can receive up to a 90-day supply of medication, which saves you money because you currently pay only $10 for generic drugs. $30 for preferred brand-name drugs, and $75 for non-preferred brand-name drugs. If your prescription costs less than the applicable copayment, you will be charged the network cost of the drug.

How to Use the Mail Order and Internet Options

1. Your doctor may prescribe ongoing medications for up to a 90-day supply, plus refills. If you are now taking medication on a long-term basis, and are ***not*** currently using the mail order option, ask your doctor for a new prescription written for a 90-day supply. A year's worth of medication would include 3 refills covering up to 90 days each.

2. To begin using mail order or to obtain envelopes, call 1-877-START MAIL. Your physician can also fax in the prescription.

3. Send the completed patient profile you receive and your original prescription(s) in the order envelope provided. Make sure you sign and complete all the information on the order envelope. Additional mailing envelopes can be ordered on the Internet at www.medco.com.

4. The mail order pharmacy will promptly process your order and send your

medications to you via U.S. mail or UPS, along with instructions for future refills. You should receive your medication and an explanation of your cost-sharing within 14 days from the date you mail your prescription.

5. Refills can be ordered via the Internet at www.medco.com or by calling the toll free number at 1-800-464-4679.

What Is Covered

Items covered under prescription drug coverage include, but are not necessarily limited to:

- Federal legend drugs that are medically necessary to treat an illness or injury and are prescribed by a doctor. This includes most recognized pharmaceuticals and generic substitutions for federal legend drugs;
- Contraceptive pills and diaphragms;
- Up to a 21-day supply of a covered drug (covered drug means insulin or any prescription legend drug, except as excluded by the Program, that is dispensed according to a prescription). Certain exceptions to the 21-day supply limit will be allowed for medications pre-packed in 30-day units (e.g., contraceptives) or for residents living in institutional settings;
- Up to a 90-day supply if purchased through mail order;
- An appropriate supply of disposable syringes and needles when prescribed for self-injection only when ordered with a supply of insulin or an antineoplastic or chemotherapeutic agent;
- Transdermal nicotine patches, covered medications or prescription legend drugs used for or in connection with the control or cessation of smoking.

For the Basic, Enhanced, and PPO options of the Salaried Health Care Program, the prescription drug carrier administers several processes that promote the appropriate prescribing of prescription medications. *These processes may include requiring prior authorization of certain medications or specifying quantity limits in line with a medically appropriate 34-day supply. The specific medications included may be modified from time to time.* Physicians can obtain prior authorization by calling 1-800-458-8001. You can obtain additional information by calling 1-800-464-4679.

What Is Not Covered

Items not covered under the prescription drug component include, but are not necessarily limited to:

- Any research or experimental agent;
- Any medication being used for a cosmetic purpose;
- Any medication for the purpose of attempting to induce pregnancy;
- Drugs prescribed for weight control or appetite suppression;
- Devices or appliances (e.g., orthotics);
- Any vaccine administered for the prevention of infectious diseases;
- Any charge for the administration of covered drugs;
- A covered drug in excess of the quantity specified by the physician;
- More than a medically appropriate 21-day supply of a covered drug provided by a retail pharmacy (except as provided for earlier), or for more than a 90-day supply of a covered drug supplied through the Mail Order Prescription Drug option; or
- Drugs received prior to the effective date of the enrollee's health care coverage.

The Maximum Allowable Cost Feature

Your prescription drug coverage includes a Maximum Allowable Cost (MAC) feature that

is a generic substitution program. Generic drugs are required to: (1) have the same active ingredients in the same dosage, (2) meet the same quality standards, and (3) have the same medical effect as brand-name drugs, though generic drugs generally cost substantially less. The MAC feature is designed to encourage use of generic drugs by limiting the amount that will be paid for certain drugs. ***When a generic equivalent is available, you're responsible for the generic copayment and the difference in cost between the generic and brand-name drug.***

If you have a question about your GM ***prescription drug coverage***, call a Customer Service Representative at: ***1-800-464-4679***.

Hearing Aid

GM provides coverage to address hearing deficiencies or loss once you have been examined by an ear specialist (otologist or otolaryngologist).

What Is Covered

If the examination by an ear specialist determines that your hearing problem may be corrected by use of a hearing aid, benefits may be provided. Following this examination, payment will be made for the following services ***when obtained from a participating provider*** and when provided in the order below, once during any period of 36 consecutive months:

- Audiometric examination (up to the reasonable and customary charge);
- Hearing aid evaluation test (up to $126, subject to periodic review and adjustment); and
- One standard hearing aid of the following designs (up to the acquisition cost plus dispensing fee):
  - In-the-ear;
  - Behind-the-ear (including air and bone conduction types); or
  - On-the-body.

- Hearing aid ear molds for children. Children under 3 years of age are eligible for four (4) molds per year. Children between 3 and 7 years of age are eligible for two (2) molds per year.

If an enrollee is 18 years of age or older, he or she will be required to have a medical examination of the ear only prior to receiving the initial hearing aid. However, enrollees under age 18 will be required to have a medical examination of the ear each time a hearing aid is dispensed.

What Is Not Covered

Services not covered under hearing aid provisions include, but are not necessarily limited to, the following:

- Audiometric examinations by an audiologist that are not ordered by a physician;
- Medical or surgical treatment;
- Drugs or other medication;
- Audiometric examinations, hearing aid evaluation tests, and hearing aids:
  - Ordered: (1) prior to the enrollee's eligibility for coverage; (2) after termination of the enrollee's coverage; or (3) while covered but delivered more than 60 days after termination of coverage;
  - For which no charge is made to the enrollee or for which no charge would be made in the absence of hearing aid coverage;
  - Which are not recommended or approved by a physician;
  - Which do not meet professional accepted standards of practice, including any service or supplies that are experimental in nature;
  - Received as a result of ear disease, defect, or injury due to an act of war;
  - Provided by any governmental agency or that are obtained by the enrollee without cost;
  - Provided under any applicable workers' compensation law.

- Replacement of hearing aids that are lost or broken;
- Replacement parts for and repairs of hearing aids;
- Charges incurred by enrollees of an HMO option;
- Eyeglass-type hearing aids, to the extent the charge exceeds the expense for one standard hearing aid;
- Binaural hearing aids except as provided to correct or prevent speech impairment, for children under age 19 who have hearing loss in both ears; and
- Digital-controlled/programmable hearing devices, to the extent the charge for such device exceeds the covered expense for a standard, conventional hearing aid.

Durable Medical Equipment (DME) and Prosthetic and Orthotic (P&O) Appliances

When a patient needs to use equipment or appliances that are prescribed by a doctor, they may be covered — whether used in a hospital or skilled nursing facility or after discharge. Coverage is provided when the attending physician prescribes such equipment, and it is approved by the carrier. Durable medical equipment and prosthetic and orthotic appliances should be obtained through the National DME/P&O network.

When covered services are received from non-network providers, you will be responsible for paying the provider and submitting the claim and supporting documentation to the carrier. The carrier will then send payment to you based upon the amount applicable to network providers. You may be required to pay the amount charged by the non-network provider in excess of the network fee schedule. Additionally, benefit payments toward the Medicare deductible or coinsurance for those individuals enrolled in the Medicare Program will ***only*** be made when services are received from a Network Provider.

You or your provider may contact the Network administrator. Northwood National Provider Network at 1-800-936-9314 for preauthorization, claims processing, assistance in locating participating providers, and for other questions or concerns.

Durable Medical Equipment (DME) — What Is Covered

Equipment and services covered under DME provisions include, but are not necessarily limited to:

- Equipment that meets Program standards which include being approved for reimbursement under Medicare Part B and being appropriate for use in the home;
- Equipment used in a hospital or skilled nursing facility or used outside the hospital or skilled nursing facility and rented or purchased from such hospital or facility;
- Repairs necessary to restore the equipment to a serviceable condition when such equipment is purchased (this does not include routine maintenance);
- Neuromuscular stimulators;
- Positioning transportation chairs as alternatives to traditional wheelchairs for child(ren) under 14 years of age, who suffer from neuromuscular disorders, closed head injuries, spinal cord disorders, or congenital abnormalities;
- External electromagnetic bone growth stimulators, in certain cases;
- Portable insulin infusion pumps and home glucose monitors for certain diabetics;
- Pressure gradient supports for certain patients; and
- Pronged and standard canes (when purchased).

Failure to use the network may result in out-of-pocket cost to you.

Durable Medical Equipment (DME) — What Is Not Covered

Equipment not covered under these provisions includes, but is not necessarily limited to, the following:

- Rented equipment that extends beyond the expiration of the original prescription, unless the physician recertifies with another prescription that the equipment continues to be reasonable and medically necessary;
- Deluxe equipment such as motor-driven wheelchairs and beds, unless medically necessary;
- Comfort, convenience, self-help, and environmental items not primarily medical in nature, such as adjust-a-beds, elevators, air conditioners, sauna baths, and non-medical supplies such as paging systems;
- Physician's equipment;
- Exercise and hygienic equipment; and
- Experimental, investigational or research equipment.

Prosthetic and Orthotic (P&O) Appliances — What Is Covered

Appliances and services covered under the P&O provisions include, but are not necessarily limited to:

- P&O appliances that are furnished by an accredited facility and meet Program standards, including being approved for reimbursement under Medicare Part B;
- Orthopedic shoes, inserts, arch supports, and shoe modifications when the shoes are part of a covered brace;
- Appliances or devices that are surgically implanted permanently within the body (except for experimental or research appliances or devices) or those that are used externally while in the hospital as part of regular hospital equipment or when prescribed by a physician for use outside the hospital;
- Replacement, repair, fitting and adjustments of the appliance;
- Wigs and appropriate related supplies for hair loss caused by chemotherapy or radiation therapy, up to $200 for the first purchase and up to $125 for subsequent purchases after each period of 12 months has elapsed; and
- Through your medical plan carrier, ***the first set*** of prescription lenses (eyeglasses or contact lenses) following a cataract operation for any disease of the eye or to replace the organic lens missing because of congenital absence (after that, eyeglass or contact lenses are covered under the vision plan).

Failure to use the network may result in out-of-pocket cost to you.

Prosthetic and Orthotic (P&O) Appliances — What Is Not Covered

Items not covered under these provisions include, but are not necessarily limited to:

- Dental appliances, hearing aids, eyeglasses, elastic stockings, or corrective footwear;
- Foot orthotics; or
- Experimental, investigational or research devices.

Hospice

The GM medical plan's hospice coverage addresses the needs of terminally ill patients who do not require the continuous level of care provided in a hospital or skilled nursing facility. For terminally ill patients to be eligible for covered hospice expenses:

- The services must be provided and billed by a hospice program that meets Program standards and is approved by the carrier;
- The enrollee must be admitted to the hospice program by order of a physician who certifies that the patient requires this type of care and has a life expectancy of six months or less; and
- The enrollee must voluntarily elect to participate in the hospice program and agree to accept the services provided as treatment of the terminal condition.

An approved hospice program is limited to a lifetime maximum of 210 days.

What Is Covered

Services covered under hospice provisions include, but are not necessarily limited to:

- Nursing care provided by or under the supervision of a registered nurse;
- Medical social services provided by a social worker under the direction of a physician;
- Physician services;
- Counseling services provided to the patient, family members, and/or other persons caring for the patient at home;
- General inpatient care provided in a hospice inpatient unit;
- Medical appliances and supplies;
- Physical, occupational, and speech therapies;
- Continuous home care provided during periods of crisis, as necessary to maintain the patient at home;
- Respite care;
- Bereavement counseling;
- Care rendered in a nursing home with hospice support; and
- Home health aide services.

Mental Health and Substance Abuse

The provisions of this section apply to enrollees of the Basic Medical Plan (BMP), Enhanced Medical Plan (EMP), and Preferred Provider Organization (PPO) options of the Program. As a BMP, EMP, or PPO enrollee, you receive such services through a managed care arrangement with a network of providers that helps you and your covered family members receive quality, appropriate care.

Participating providers are authorized by CIGNA Behavioral Health (CBH) to deliver care for you and your family members. You may be directed to the appropriate panel provider by CBH. ***All non-emergency inpatient services must be delivered by a participating provider to be eligible for maximum coverage.*** Emergency detoxification is the only substance abuse treatment service that may be delivered by a non-participating provider.

CBH has a toll-free telephone number that is available 24 hours a day. If you have questions regarding your mental health/ substance abuse coverages or need services, call 1-888-865-2960. ***Remember, you must use panel providers to receive full benefits.***

Treatment Options

Mental health and/or substance abuse treatment is generally delivered in one of two ways:

- Inpatient — with an admission to a panel facility; or

- Outpatient — by periodic visits to a participating provider or facility.

A continuing care treatment plan is designed to facilitate effective delivery of services for substance abuse patients. A patient entering detoxification, residential, or halfway house facilities is required to receive a treatment plan as part of his or her assessment. Completion of the plan as prescribed is necessary.

Inpatient Care — What Is Covered

*Note: Inpatient treatment can be delivered as hospital care or in one of several alternative treatment facilities. To be covered, your stay at an inpatient treatment facility must be approved by CBH within 24 hours of your admission. Treatment at a residential facility always must be approved **prior** to treatment.*

Services covered under the mental health and substance abuse treatment provisions include, but are not necessarily limited to:

- Up to 45 days of approved hospital care or up to 90 days of treatment in an approved partial hospitalization facility during the benefit period, including:
  - Semiprivate room with general nursing services, meals and special diets;
  - Laboratory and pathology (hospital care only) examinations;
  - Drugs, biologicals, solutions, use of equipment and supplies related to the treatment;
  - Professional and ancillary services;
  - Individual and group therapy;
  - Counseling for family members;
  - Electroshock therapy; and
  - Supplies and use of equipment required for detoxification or rehabilitation of substance abuse patients (hospital care only);

- Psychological testing when administered by a panel psychologist and approved by CBH;

- Treatment of mental disorders, limited to individual and group psychotherapeutic treatment, family counseling, psychological testing prescribed or performed by a physician, and electroshock therapy;

- ***Up to 90 days of approved*** skilled nursing facility care for ***mental health services only****;*

- ***Up to a 90-day lifetime*** treatment in an approved halfway house for ***substance abuse treatment*** including:
  - Bed and board;
  - Intake evaluation;
  - Up to one routine drug screen per week;
  - Individual and group therapy or counseling; and
  - Counseling for family members.

When both inpatient hospital services and treatment in a partial hospitalization or skilled nursing facility are required, coverage limits take into account the combined treatment. Each day of inpatient hospital care for any condition (including non-mental health or substance abuse conditions) is equivalent to two days of partial hospitalization facility treatment or skilled nursing care.

For example, if an enrollee is admitted to the hospital for one day of inpatient care, coverage may be provided for up to 88 days (90 minus 2) of partial hospitalization or skilled nursing care. Or, after two days of skilled nursing care, an enrollee may be covered for up to 44 days (45 minus 1) in the hospital. One day of inpatient care uses two days of partial hospitalization or skilled nursing care.

Outpatient Care — What Is Covered

*Note: Outpatient treatment does **not** require a hospital stay or admission to a treatment facility. It is delivered during visits to a participating provider. Emergency outpatient treatment requires authorization through CBH within 24 hours of your first visit.*

Services covered under these provisions include, but are not necessarily limited to:

- Outpatient services provided and billed by a facility:
  - Professional staff and ancillary services to ambulatory patients;
  - Prescribed drugs and medications dispensed by a facility in connection with treatments;
  - Electroshock therapy for a mental health patient;

- Outpatient services provided and billed by facilities or professional providers including:
  - Individual psychotherapeutic treatments, group mental health and substance abuse treatment, and family counseling to members of patient's family:
    - 20 mental health visits per year at 100% coverage;
    - Additional 15 mental health visits per year at 75%; and
    - 35 substance abuse visits per year at 100% coverage;

- Panel providers are required to verify eligibility and receive prior authorization for all non-emergency substance abuse treatment;

- Coverage will be limited to the following when rendered by or through non-panel providers:
  - Emergency services. Providers must contact CBH within 24 hours of the inpatient admission or outpatient treatment for authorization of such services;
  - Non-emergency services. Benefits for mental health services provided by non-panel providers without referral by a panel provider are limited to 50% of the panel reimbursement amount. The carrier will make payment to the primary enrollee. Payment to the provider, including any balance, is the responsibility of the enrollee;
  - Outpatient services. Services provided by non-panel physicians (e.g., internists or general practitioners) must be registered with CBH after the first visit and are limited to a maximum of one (1) visit.

What Is Not Covered

Certain health care services and charges described in the mental health and substance abuse coverage are excluded or limited, as set forth below:

- Coverage for substance abuse treatment does not include services provided by non-panel providers except for emergency detoxification;

- Coverage is not available for:
  - Services for treatment of mental disorders that are not amenable to favorable modification, except for the period necessary to determine that the disorder is not amenable to favorable modification;
  - Substance abuse treatment professional services such as dispensing methadone, testing urine specimens, or performing physical or x-ray examinations unless therapy, counseling, or psychological testing are provided on the same day;
  - Family counseling rendered by a provider other than the provider for the family member in the course of treatment;
  - Diversional therapy;
  - Psychological testing in connection with vocational guidance, training or counseling; or
  - Tobacco use disorder.

General Limitations and Exclusions

Certain health care services and charges described in the previous sections are excluded or limited. The following are some but not necessarily all of these services:

- Services provided after an enrollee's coverage under this Program is terminated except for physician and hospital, skilled nursing facility, or residential substance abuse facility services for continuous, predetermined

and approved inpatient admissions which commence prior to the termination date of the coverage;

- Private duty nursing services;
- Upgraded room accommodations;
- Dental services;
- Treatment for temporomandibular joint (TMJ) dysfunction;
- Chemotherapy services or supplies when the treatment is research, investigational, or experimental in nature;
- Services, care, treatment, or supplies that are not medically necessary according to accepted standards of medical practice;
- Care, services, supplies, or devices which are experimental, research, or investigational in nature;
- Personal or convenience items;
- Services for premarital or pre-employment examinations;
- Charges determined by the carrier to be unreasonable;
- Services related to any condition, disease, ailment, or injury arising out of or in the course of employment for which the employer pays or provides reimbursement under the provisions of any law of the U.S.;
- Services for which a charge would not have been made if no coverage existed;
- Services available through other programs (e.g., Medicare);
- Services provided to the enrollee by members of the enrollee's household or immediate relatives of the enrollee;
- Care, services, supplies, or devices related to custodial or domiciliary care provided in an institutional setting;
- Care, services, supplies, drugs, or devices for the purpose of inducing pregnancy;
- Travel time or expenses;
- Special education facilities and tutoring for learning disabilities or correction of behavioral problems;
- Food, dietary supplements, or vitamins;
- Services, supplies, or equipment not performed by, prescribed by, or rendered by a physician;
- Charges for miscellaneous services, such as acupuncture, massage, hypnotherapy, etc.;
- Charges for missed appointments, room or facility reservations, completion of any claim forms, or record processing; and
- Bone marrow transplant services under certain conditions.

Extended Care Coverage

When long-term hospital, skilled nursing or custodial care is required, Extended Care Coverage (ECC) provides for certain services not covered by your medical plan. The maximum benefit payable under this coverage for services incurred during any one calendar year is $50,000 for each enrollee. You are eligible for ECC regardless of whether you have elected the BMP, EMP, PPO, or HMO, unless you have previously waived ECC for a reason other than being a dependent under the coverage of a salaried employee or retiree with ECC.

Who Is Covered

Retirees and surviving spouses eligible for Medical Plan coverage may elect to continue ECC coverage at the time of retirement. Retirees and surviving spouses who elect not to continue this coverage will not be permitted to re-enroll. Individuals enrolled as Sponsored Dependents are ***not*** eligible for ECC coverage.

What Is Covered

Services covered under Extended Care Coverage (ECC) provisions include, but are not necessarily limited to, the following:

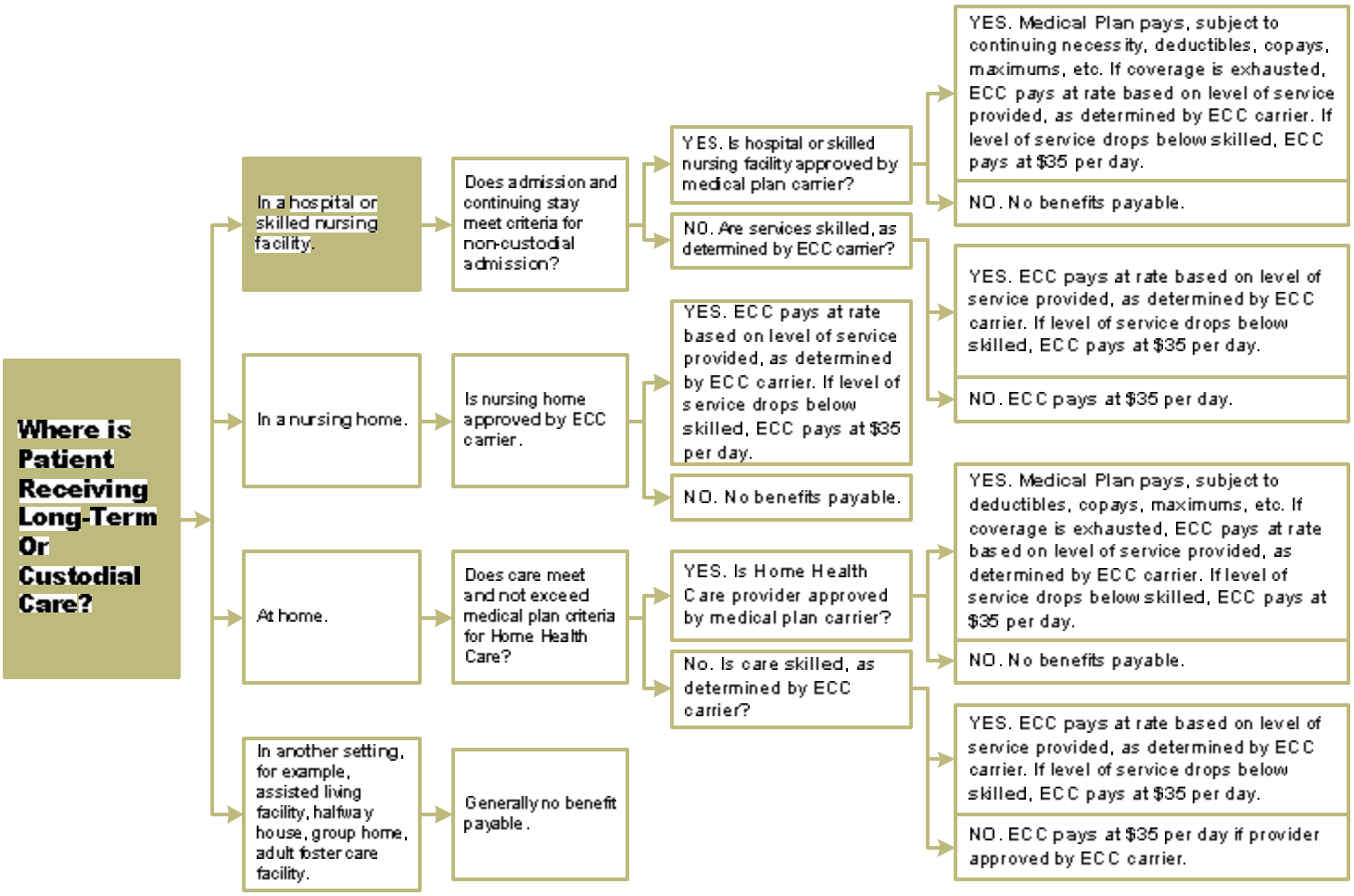
- Medically necessary, non-custodial hospital or skilled nursing facility admissions which exceed the medical plan limits;
- Skilled hospital or skilled nursing facility admissions which are not covered under the medical plan due to the medical plan carrier's determination that the admissions are custodial in nature;
- Admissions to nursing homes approved by the ECC carrier, for services considered by the ECC carrier to be skilled in nature;
- Skilled care being provided in the home by a qualified home health care agency or by a qualified nurse professional but which does not meet the criteria for coverage under the medical plan provisions;
- Unskilled care delivered in a hospital, skilled nursing facility, nursing home, or in the patient's home by nurse professionals approved by the ECC carrier (up to $35 per day); and
- Medical supplies not covered under other Program provisions (e.g., prescription drugs, durable medical equipment) for an enrollee admitted to a hospital or skilled nursing facility for unskilled custodial care.

Limitations and exclusions to the ECC coverage include, but are not necessarily limited to, the items below:

- Services in the home in connection with routine nursing care of newborn child(ren);
- Services not prescribed by a physician;
- Education or training (including such services when directed toward learning, behavioral, or developmental deficiencies);
- Amounts covered by public programs providing benefits (such as those under laws pertaining to workers' compensation, non-occupational disability, old-age assistance, veteran's assistance, and any federal or state health insurance act providing nursing benefits);
- Amounts reimbursed by Medicare;
- Amounts in excess of the reasonable and customary charge or which are not considered to be necessary as determined by the carrier;
- Charges which duplicate benefits paid under another section of the Program;

- Services provided by a person related to you by blood or marriage;
- Services provided by an assisted living facility, a halfway house, group home, adult foster care facility, and the like;
- Services provided by a non-licensed facility;
- Non-medical supplies including, but not limited to, personal hygiene products, over-the-counter medications, and personal items (including disposable briefs and diapers);
- Private duty nursing services for patients admitted to hospitals, skilled nursing facilities, or nursing homes;
- Mental health/substance abuse care exceeding the medical plan coverage; and
- Charges for services rendered prior to the effective date of, or after termination of coverage under the Program.

Extended Care Coverage



Dental Coverage

GM provides Dental Plan coverage for services and supplies necessary for the treatment of many dental conditions but only to the extent that related charges are reasonable and customary as determined by the carrier and if such services are rendered in accordance with accepted standards of dental practice.

Dental coverage is provided through either a traditional option or a managed dental care plan, known as an Alternative Dental Plan (ADP). GM's dental coverage has cost-sharing components for participation and for certain services. It also includes limits on the benefits you may receive. ***If a course of treatment is expected to involve covered dental expenses of $200 or more, carrier predetermination is required. The carrier for GM's traditional dental coverage is MetLife.***

Under ADPs, to receive full coverage, you must use a dentist who is a member of the plan's network. Benefits may not be provided, or may be reduced, if you receive services from a non-network dentist.

Coverage under available ADPs varies from plan to plan and may differ from GM's traditional dental coverage. The certificate you receive from the ADP contains specific information about cost-sharing provisions, including lifetime caps or limitations, services requiring reauthorization and/or utilization review, and rules for selection of providers. Provider directories are available, without charge, at the ADP's website, or by calling their toll-free number.

Traditional Dental Plan Benefits

If your dentist recommends treatment with an expected cost of $200 or more, a description of the procedure and estimate of the charges should be filed with MetLife prior to commencing the course of treatment. After considering alternate procedures, services, and courses of treatment, your carrier will inform you and your dentist of the charges to be covered for the course of treatment in question. The predetermination process is not necessary for courses of treatment under $200 or for emergency treatment, routine oral examinations, x-rays, prophylaxes, and fluoride treatments.

Failure to file a description and estimate of your course of treatment prior to treatment could result in you being faced with higher than anticipated out-of-pocket expenses.

What Is Covered

Services covered under dental provisions include, but are not necessarily limited to, the following:

- ***Preventive*** dental services at 100% of the reasonable and customary charge:
  - Two routine oral examinations and cleanings (scaling and cleaning of teeth) within a calendar year; up to three cleanings per calendar year will be allowed if you have a documented history of periodontal disease. Up to four cleanings per calendar year will be covered for two full calendar years following periodontal surgery;
  - Fluoride treatments, only if under 20 years of age (unless specific dental condition makes such treatment necessary);
  - Space maintainers to replace prematurely lost teeth for child(ren) under 19 years of age;
  - Emergency palliative treatment;

- ***Minor restorative*** services at 90% of the reasonable and customary charge:
  - Dental x-rays, including: full mouth x-rays once in any five consecutive calendar year period; bitewing x-rays once per calendar year; other dental x-rays as required in connection with the diagnosis of a specific condition requiring treatment;
  - Extractions;
  - Oral surgery;

- Amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations;
- General anesthetics and intravenous sedation when medically necessary and administered in connection with oral or dental surgery;
- Treatment of periodontal and other diseases of the gums and tissues of the mouth;
- Endodontic treatment, including root canal therapy;
- Injection of antibiotic drugs by the attending dentist;
- Repair or recementing of crowns, inlays, onlays, bridgework, or dentures; or relining or rebasing of dentures more than six months after the installation of an initial or replacement denture, but not more than one relining or rebasing in any three year period;
- Inlays, onlays, gold fillings, or crown restorations, only when the tooth cannot be restored with other filling restoration;
- Cosmetic bonding of eight front teeth for child(ren) 8 through 19 years of age, under certain conditions, but not more frequently than once in any three year period.

- ***Major Restorative*** services at 50% of the reasonable and customary charge:
  - Initial installation of fixed bridgework (including inlays and crowns as abutments);
  - Initial installation of partial or full removable dentures (including precision attachments and any adjustments during the six-month period following installation);
  - Replacement of an existing partial or full removable denture or fixed bridgework under certain circumstances. (Note: Dentures will be customarily replaced by dentures, but if a professionally adequate result can be achieved only with bridgework, such bridgework will be covered);

- ***Orthodontic*** procedures and treatment at 50% of R&C (including related oral examinations), for a covered individual ***under 19 years of age when treatment commences up to a lifetime maximum of $2,000 per enrollee***;

- ***Treatment of temporomandibular joint (TMJ) dysfunction*** including, but not limited to, related oral examinations, consultations, x-rays, occlusal equilibration, diagnostic models, and casts, temporary splints, and orthotic appliances, limited to $2,000 during the lifetime of the enrollee. (It does not include orthodontic treatment, except as in the above); and

- ***Accidental dental injury*** services for repair and/or care of ***natural teeth***. For this component to apply,
  - The annual maximum benefit must be exhausted;
  - The accident must be documented;
  - The services must be a direct result of the accident and are provided within one year of the accident; and
  - Benefits are subject to a reasonable and customary charge, a 20% copayment, and a maximum benefit payment of $12,000 per qualified occurrence and per lifetime.

The ***maximum benefit*** payable for ***all*** covered dental expenses during any calendar year is $1,700 per covered person. For expenses in connection with orthodontics, including related oral examinations, the maximum ***lifetime*** benefit per eligible covered individual is $2,000. For expenses for treatment of TMJ, the maximum ***lifetime*** benefit equals $2,000 per covered individual. For accidental injury the ***lifetime*** maximum is $12,000.

Certain dental care services and charges are limited. Please consult with MetLife concerning these limitations.

What Is Not Covered

Services not covered under dental provisions include, but are not necessarily limited to, the following:

- Charges for services covered under other health care coverages;
- Charges for:
  - Treatment by someone other than a dentist;
  - Veneers or similar properties of crowns and pontics for certain teeth;
  - Services or supplies that are cosmetic in nature;
  - Prosthetic devices, crowns, inlays, and onlays and their fitting ordered while you were not covered;
  - Replacement of a lost, stolen or missing prosthetic device;
  - Failure to keep a scheduled visit with a dentist;
  - Replacement or repair of an orthodontic appliance;
  - Services or supplies compensable under workers' compensation or employer's liability law;
  - Services rendered through a facility provided or maintained by GM;
  - Services or supplies that the enrollee is not legally obligated to pay or for which no charge would be made in the absence of dental coverage;
  - Services or supplies that are not necessary, recommended, or approved by the attending dentist;
  - Services or supplies that are experimental in nature;
  - Any duplicate prosthetic device or appliance;
  - Completion of any insurance forms;
  - Sealants, oral hygiene and dietary instruction;
  - A plaque control program;
  - Dental implants and/or implantology; or
  - Services or supplies related to periodontal splinting.

A Closer Look at Your Dental Options

	Traditional Dental Plan		Alternative Dental Plan (ADP) where available
Monthly contributions	Yes		Yes
Deductible	None		None
Copayment:	Plan Pays*	You Pay*	Copayments, benefit maximums and covered services vary from plan to plan and may differ from the Traditional Dental Plan. (Contact the ADPs available in your area for more information.)
■ Preventive	100%	0%	
■ Minor restorative	90%	10%	
■ Major restorative	50%	50%	
■ Orthodontics	50%	50%	
■ TMJ dysfunction	50%	50%	
Annual maximum benefit	$1,700 per covered person		
Lifetime orthodontic maximum benefit	$2,000 per covered person under age 19		
Lifetime TMJ maximum benefit	$2,000 per covered person		
Lifetime accidental dental injury maximum benefit	$12,000 per covered person		

* *Plan payments are based on reasonable and customary charge levels as determined by your carrier.*

Vision Coverage

GM's vision coverage provides assistance toward the cost of routine eye exams, lenses, and frames through a national network of participating providers, which includes ophthalmologists, optometrists, and optical facilities.

The carrier for GM's vision coverage is Cole Managed Vision.

What Is Covered

Services covered under vision provisions include, but are not necessarily limited to, the items below:

- One vision examination per calendar year including refraction, case history, coordinating measurements, and tests;
- Prescription of glasses where indicated;
- Examination by an ophthalmologist, upon referral by an optometrist, within 60 days of a vision examination by the optometrist;
- Materials and professional services connected with the order, preparation, fitting, and adjusting of:
  - — Normal size lenses (single vision, bifocals, trifocals, lenticular) once per calendar year;
  - — Number 1 or 2 tint for lenses;
  - — Contact lenses in lieu of regular lenses:
    - Following cataract surgery;
    - When visual acuity cannot be corrected to 20/70 in the better eye;
    - When medically necessary due to keratoconus, irregular astigmatism, or irregular corneal curvature; or
    - Up to $80 if prescribed for any other reason than those listed above;
  - — Frames once during two consecutive calendar years;
- Limited coverage for corrective eye surgery (e.g., LASIK, PRK, RK). The maximum benefit for corrective eye surgery will be $295 in any four (4) year period. If you receive benefits for corrective eye surgery, you will be ineligible for material benefits (frames, lenses) for that year and three (3) subsequent years. You will still be eligible for an annual vision exam. Further, Enrollees will retain access to material discounts should they need material items during the time of any "lock-out" period.

What Is Not Covered

Services not covered under vision provisions include, but are not necessarily limited to, the following:

- Any lenses that do not require a prescription;
- Medical or surgical treatment of the eye;
- Drugs or any other medication;
- Procedures determined by the carrier to be special or unusual (e.g., orthoptics, vision training);
- Vision examinations, lenses, or frames obtained without cost to you; and
- Vision examinations performed and lenses and frames ordered before you become eligible for coverage or after the termination of your coverage.

Vision Network

The National Vision network is made up of vision providers who have agreed to accept reimbursement based on a fee schedule, to meet certain contractual standards for quality, and to provide a selection of frames available to GM enrollees at no cost.

Going to a participating network provider will reduce your out-of-pocket expenses. First of all, you will have no copayments or out-of-pocket expense for covered vision services such as a routine vision exam, regular size

lenses, certain designated frames or medically necessary contacts. Secondly, if you choose to upgrade your frame selection by choosing a more expensive frame, the retail price of the frame will be discounted. Finally, there are many popular non-covered lens features whose prices are limited or "capped" under the participating provider agreement.

In addition, participating providers can check on your eligibility, file your claim and be authorized by you to receive the reimbursement for covered services directly from the carrier. Information about participating providers in your area is available, without charge, by calling 1-800-638-0166.

Out of Network

Generally, if you choose to receive covered vision services from a non-participating provider you will be required to reimburse the provider and file your own claim with Cole Managed Vision. Cole Managed Vision will reimburse you directly based on a fee schedule. There is one exception. Your reimbursement for a vision exam provided by a non-participating ophthalmologist will be based on the reasonable and customary charge as established by the carrier, minus a $7 copay.

Out of Area

If you live more than 25 miles from a participating provider and choose to receive covered services from a non-participating provider, then your reimbursement will be based on reasonable and customary charges as determined by the carrier, minus a $7 copayment for exams and a $10 combined copayment for lenses and frames.

Summary

This chart summarizes the benefit frequency and the level of reimbursement for covered vision services when received In Network, Out of Network, or Out of Area.

BENEFIT	FREQUENCY	NETWORK PROVIDER	OUT OF NETWORK	OUT OF AREA*
VISION EXAM	Once each calendar year.			
Optometrist		Covered in full.	Enrollee reimbursed $37.	Enrollee reimbursed based on R&C** minus $7 copay.
Ophthalmologist		Covered in full.	Enrollee reimbursed based on R&C** minus $7 copay.	Enrollee reimbursed based on R&C** minus $7 copay.
FRAMES	Once every two consecutive calendar years.	Covered in full if selected from designated display (all other frames: covered to $24 after 30% discount).	Enrollee reimbursed $24.	Enrollee reimbursed $24 minus a $10 copay, if applicable.***
LENSES	Once each calendar year.	Covered lenses available at no cost. (Additional lens options are not covered).	Enrollee reimbursed based on a fee schedule.	Enrollee reimbursed based on R&C** minus $10 copay.
CONTACT LENSES	Once each calendar year in place of regular lenses.	Enrollee pays difference between provider's charge and $80.	Enrollee reimbursed $70.	Enrollee reimbursed $80 minus $10 copay.
CORRECTIVE EYE SURGERY	Once every four consecutive years.	Enrollee reimbursed $295.****	Enrollee reimbursed $295.****	Enrollee reimbursed $295.****

** Out of Area occurs when there is no network provider within 25 miles of the enrollee's residence.*
*** R&C stands for reasonable and customary charges.*
**** There is a combined annual copayment of $10 for lenses and frames.*
***** An enrollee receiving benefits for corrective eye surgery will be ineligible for material benefits (frames, lenses and contact lenses) for three (3) subsequent years. A corrective eye surgery claim form is necessary for reimbursement.*

Coordination of Benefits (COB)

If you or your dependents are covered by another employer's medical, dental or vision plan, the benefits/coverages will be coordinated between the two plans. To determine how to coordinate the coverage under the two plans, it is first necessary to determine which plan pays first.

The primary plan will pay first, without consideration to any other plan, according to the guidelines of its coverage. The secondary plan does not consider a claim for benefits until the primary plan pays or denies the claim. The secondary plan then follows its procedure to determine its payment, coordinated with the payment already made by the primary plan.

Because you are a retiree, your GM plan usually will be primary for most of ***your*** health care claims. If you are also covered as a dependent under your spouse's plan, you should submit your claim to the carrier of your spouse's plan after your claim has been processed under the GM plan.

If your spouse is covered by your GM Salaried Health Care Program coverage and if your spouse is employed and covered under his or her employer's plan, then that employer's plan is the primary coverage for your spouse's claims.

Your spouse's claims should be submitted to the GM plan after being processed under the spouse's plan.

If your dependent child(ren) is covered by both your plan and your spouse's plan, the "Birthday Rule" applies.

The Birthday Rule

The primary plan for your child(ren)'s coverage is the plan of the parent whose birthday comes first in the calendar year.

If you and your spouse have the same birthday, then the plan that has covered your child(ren) for the longer period of time is primary.

A different guideline applies for your dependent child(ren) if you are divorced or legally separated. In this situation:

- The plan of the parent who has legal custody of the dependent child(ren) is that child(ren)'s primary plan unless an appropriate court order states otherwise; and the plan of a step-parent with whom the child(ren) resides will pay before the plan of the parent without custody.

If none of these rules establish which plan is primary, the plan that has covered the person for the longer time becomes the primary plan.

When the GM Salaried Health Care Program Is Secondary for a Claim

The GM Salaried Health Care Program calculates the amount it would pay as if there were no other coverage. The amount of benefits actually payable by the other plan for services covered by the GM plan is then subtracted from the amount the GM plan would have paid. The GM plan pays the difference, if any. In other words, if the primary plan's payment meets or exceeds the amount the GM plan would have paid alone, no further payment is made. ***Through the COB process, you cannot receive any more than the total amount of the charge***.

When there are multiple coverages, you must first file the claim with the primary health care plan. After you have received written notification of payment or denial from the primary carrier, you should make a copy of it and submit it to the carrier of the secondary plan.

Under the GM Program, you will receive credit toward satisfying deductibles and out-of-pocket maximums ***even though the primary plan***, rather than you, ***is making the payment.*** GM uses a similar arrangement to coordinate payments from its plan with those paid by Medicare Part B, for individuals who have Medicare coverage that is primary.

Coordination of Benefits Example #1

John is married to Mary, a GM salaried retiree who elected the Basic Medical Plan for herself and her spouse. John has other coverage through his employer and it pays 70% of covered expenses with no deductibles. That coverage is primary for John. The GM coverage he has through Mary is secondary.

Assume that John submits a bill for $200 in covered expenses and that the deductibles applicable to Mary's GM coverage have already been satisfied for the year. Here's how benefits would be paid:

John submits the expense to his plan, which is primary:

Expense	$200
His plan pays 70%	$140
Remainder	$ 60

After payment from his primary plan, John submits the total expense to the GM Basic Medical Plan, along with a statement of payment action by his plan.

Expense	$200

What the Basic Medical Plan would have paid:

At 75% if it were John's only coverage	$150
What John's primary plan paid	$140
What the Basic Medical Plan will pay	$ 10

Credit applied to the out-of-pocket limit for John under the GM Basic Medical Plan ($200 - $150)	$ 50

Coordination of Benefits Example #2

Bob is a GM salaried retiree who elected traditional dental coverage. Bob's spouse, Sue, has dental coverage through her employer, which covers most procedures at 80% of reasonable and customary charges as determined by the carrier. Assume that Sue recently had covered expenses of $200.00 and that the charges were not greater than either carrier's determination of reasonable and customary.

Since her plan is primary, these expenses were first sent to her dental plan administrator for consideration.

Expense	$200
Primary pays 80%	$160

After the payment from her primary plan is received, Bob can submit the dental services received by his spouse for additional consideration under GM dental coverage, along with a statement of payment action from the primary plan. Assume in this case that the procedures performed are payable at 90% of reasonable and customary charges as determined by the carrier under GM dental coverage.

If GM dental coverage had been primary

Expense	$200
GM dental pays 90%	$180

What GM dental coverage will pay as the secondary payer

GM dental plan would have paid	$180
Primary plan paid	$160
What GM coverage will pay	$ 20

The amount applied toward Sue's annual maximum at GM will be what GM would have paid or $180. Sue's remaining calendar year maximum is $1,320 ($1,500-$180).

Administrative Provisions

How to File a Claim

Claims should be filed with the appropriate carrier as services are rendered and expenses are incurred. However, ***claims for all health care services must be submitted not later than the end of the calendar year following the year in which services are rendered.***

Your social security number (or an alternative identification number issued to you by your carrier) always is needed when you communicate with any of the carriers. If you are a dependent, the social security number (or alternative identification number) of the retiree, or surviving spouse through whom you have the coverage is needed.

Preauthorization of Services

If you are enrolled in the BMP, the EMP or the PPO, you must predetermine any hospital stay (except emergency or maternity), surgery, skilled nursing facility admission or home health care visit. Emergency hospital admissions must be reported within 48 hours of inpatient admission. See pages 21-22 for information on this predetermination requirement for medical services.

In addition, if you are enrolled in the BMP, the EMP or the PPO, certain mental health or substance abuse services will require the use of panel providers to be eligible for maximum coverage. See page 39 for information on the use of panel providers for mental health or substance abuse services.

Basic Hospital, Medical, and Surgical Claims

If your carrier is a Blue Cross or Blue Shield plan, show your health care identification card when you go to the hospital, residential or outpatient treatment facility, physician, or other provider of covered services anywhere in the country. Usually, a hospital or other facility is paid directly by Blue Cross for covered services. Blue Shield generally pays physicians directly for covered services. In any situation where a provider of a service is not paid directly by Blue Cross-Blue Shield, you should submit the charges to your local Blue Cross-Blue Shield plan office. **You should always check with your provider or with Blue Cross-Blue Shield, before you receive services, to make sure you use "participating" providers for your medical care needs.** Participating providers generally have agreed to accept a negotiated fee from Blue Cross-Blue Shield for covered services which can reduce the your out-of-pocket costs. If you seek care from a non-participating provider, benefit reimbursement may be severely limited and you may be required to pay the bulk of the non-participating provider's fee for services rendered.

If your carrier is United Health Care, show your health care identification card when you go to the hospital, residential or outpatient treatment facility, physician, or other provider of covered services anywhere in the country. Payment will be made directly to providers who participate in United Health Care's network. Providers who do not participate in United Health Care's network may require you to pay their bills directly and you will be required to file a claim for reimbursement. In that case, United Health Care will pay you the appropriate amount.

Prescription Drug Claims

When you use a network provider, your claims for services will be filed electronically with Medco Health by the provider. If you obtain services from a non-network provider, you will be required to pay the full charge and file a claim. Claim forms may be obtained by calling Medco Health. You and/or the provider may complete all the required information on the form. You may then mail the claim to the address noted on the form. You will be reimbursed the appropriate amount after your copayment has been deducted.

Mental Health and Substance Abuse Claims

Because the mental health and substance abuse coverages utilize a closed panel of approved providers, the facility, or other provider, generally will have a supply of claim forms.

Claim forms also may be obtained from the office that administers your health care benefits. ***If it becomes necessary for you, instead of the facility or provider, to submit a claim form to Connecticut General Life Insurance Company (CG)*** (e.g., you receive outpatient mental health treatment from a non-panel physician provider to whom you must make payment before you may seek reimbursement from CG), you are required to send the originals of either (1) itemized bills, (2) statements, or (3) receipts for each of the medical expenses for which you are claiming payment.

Hearing Aid Claims

Because only approved or participating providers are eligible for reimbursement, such providers generally will have the necessary hearing aid claim forms. Benefits will be paid directly to the provider by the carrier. ***Benefits are payable only if you obtain hearing aid services from a participating provider, and only if they are obtained in the appropriate sequence.*** Ask the provider if he or she is participating, ***before*** you receive services. Information about participating providers is available, without charge, from your medical carrier.

Durable Medical Equipment (DME) and Prosthetic and Orthotic (P&O) Claims

Durable medical equipment and prosthetic and orthotic appliances should only be obtained from the National DME/P&O network. By using network providers, you will not have to file claim forms, nor will you receive balance due billings from providers.

When covered items or services are received from non-network providers, you will be responsible for paying the provider and submitting the claim and supporting documentation to the carrier. The carrier will then send payment to you based upon the amount applicable to network providers. You may be required to pay the amount due to the provider that is in excess of network fee schedules.

Contact the network administrator, Northwood National Provider Network, at 1-800-936-9314 with any questions pertaining to the network.

Dental Claims

Dental claim forms and instructions generally are available from dentists in areas where there are GM employees and retirees. Also, claim forms are available from MetLife.

If a course of treatment is expected to involve dental expenses amounting to $200 or more, prior to the commencement of treatment, you should have your dentist submit a description of the procedures to be performed and an estimate of the charges to MetLife. They will notify the dentist and you of estimated benefits payable, with consideration given to alternate procedures that may be performed to accomplish the desired results.

Vision Claims

Cole Managed Vision is the current vision coverage carrier. A claim form may be obtained from a participating provider, by contacting the GM Benefits & Services Center, by accessing the web (gmbenefits.com), or calling Cole Managed Vision. Complete your portion of the form and have the remaining portion completed by the provider. The completed form should be sent to Cole Managed Vision. Payment will be made directly to a participating provider, unless you have paid all, or part, of the charges for covered services. In that case, the carrier will pay you the appropriate amount. Payment for covered services received from a non-participating provider will be sent to you.

Extended Care Coverage (ECC)

You should obtain the necessary forms from Connecticut General by calling 1-800-523-4626. ***There are things you should do routinely to prepare for filing the claim:***

- Obtain all bills and receipts for medical services incurred by you and your covered dependents;
- Be sure bills and receipts are properly identified, separated by individual, and in chronological order;
- Ensure that the bills or receipts are itemized and include the patient's name, description of service or medical supply, date of service or purchase, and charges incurred;
- Submit "Explanation of Benefit" statements from your medical coverage carrier and, if applicable, "Medicare Explanation of Medicare Benefit" statements, with appropriate bills or receipts;
- Be sure that receipts for medical supplies, equipment, private duty nursing, physical therapy, or other services not performed by a physician are supported by certification of the attending physician and that such supplies, equipment, or services are medically necessary; and
- Be sure that claims are filed not later than the end of the calendar year following the year in which services are rendered.

Appealing a Pre-Service or a Post-Service Claim Determination

Mandatory Appeal Procedure

If you wish to appeal an adverse claim determination, you must submit your appeal in writing within 180 days from the initial claim determination. Follow the instructions provided on the Explanation of Benefits (EOB) you receive from the carrier and send your written appeal to the address of the appropriate carrier. In the case of a claim involving urgent care, when the services in question require pre-authorization, you may initiate the appeal by a telephone call to the appropriate carrier.

For an appeal regarding eligibility under the Program, you must direct your written appeal to the GM Benefits & Services Center, P. O. Box 770003, Cincinnati, OH 45277-1060.

Health Maintenance Organizations (HMOs) and Alternative Dental Plans (ADPs) each have their own appeal process which must be followed in all circumstances, other than questions regarding eligibility for participation in the GM Salaried Health Care Program. If you wish to appeal a claim determination, write directly to the HMO or ADP at the address given on the initial claim determination or in your certificate. HMOs and ADPs are responsible for formulating their own medical policy. Decisions resulting from their appeal process are final.

If you are enrolled in the Basic Medical Plan, Enhanced Medical Plan, Preferred Provider Organizations or Traditional Dental Plan, and you wish to appeal the denial of a health care claim, write to your local carrier and include in your correspondence the following:

- A copy of the Explanation of Benefits (EOB) you received from the carrier;
- Any additional information/ documentation to be considered;
- The reason why you believe the denial was incorrect.

If a claim meets the definition for urgent care under applicable federal regulations, the request may be submitted by telephone. As part of the review, you may submit any written comments that may support the claim. A written decision on the request for review will be furnished to you as follows:

- **Urgent Care Claims -** In the case of a claim involving urgent care, as defined by applicable regulations, the carrier shall notify you of the benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review of an adverse benefit determination.

- **Pre-service Claims** - In the case of a pre-service claim, as defined by applicable regulations, the carrier shall notify you of the benefit determination on review within a reasonable period of time, appropriate to the medical circumstances, but not later than 30 days after receipt by the carrier your request for review of an adverse benefit determination. In the case of a carrier that provides for two appeals of an adverse determination, such notification shall be provided, with respect to any one of such two appeals, not later than 15 days after receipt by the carrier of your request for review of the adverse benefit determination.

- **Post-service Claims** - In the case of a post-service claim, as defined by applicable regulations, the carrier shall notify you of the benefit determination on review within a reasonable period of time, but not later than 60 days after receipt by the carrier of your request for review of an adverse benefit determination. In the case of a carrier that provides for two appeals of an adverse determination, such notification shall be provided, with respect to any one of such two appeals, not later than 30 days after receipt by the carrier of your request for review of the adverse benefit determination.

Under the mandatory procedure, the carrier has discretionary authority to construe, interpret, apply and administer the Program.

Once you have completed the appeal process offered by the carrier, you may bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 or you may continue to pursue your appeal under the Voluntary Review Process.

Voluntary Review Process

Your decision to submit an adverse claim determination for review under the GM Voluntary Review Process will not have an effect on your rights to any other benefits under the GM Salaried Health Care Program.

You can elect to submit an adverse claim determination for review under the Voluntary Review Process only after exhaustion of the mandatory appeal procedure described above. The carrier's final determination completes the mandatory appeal procedure.

Any statute of limitations or other defense based on timeliness is tolled during the time that the voluntary review is pending. The Program waives any right to assert that you have failed to exhaust administrative remedies because you did not elect to submit a claim determination for review under the voluntary process.

You have a right to legal representation. However, representation is not required under the Voluntary Review Process. The Program will impose no fees or cost for review.

To utilize the voluntary process, submit your written appeal to the GM Benefits & Services Center, P.O. Box 770003, Cincinnati, OH 45277-0066 including with your correspondence the following:

- A copy of the initial EOB;
- Copies of any information you sent to the carrier when you appealed;
- The carrier's decision on the appeal;
- All previous responses;
- The basis for requesting a redetermination; and
- Other pertinent documentation.

The following is a summary of the GM Voluntary Review Process.

Step one is a review by a Benefits Administrator at the GM Benefits & Services Center.

Step two is a review by the Assistant Director of the GM Benefits & Services Center.

Step three is a review by the Plan Administrator whose role is to determine whether the Program provisions have been applied properly. For services determined to be research, experimental or investigational in nature, an additional review step may be made available. The Plan Administrator is required to follow the terms of the Program and has discretionary authority to construe, interpret, apply and administer the Program.

The Plan Administrator will respond in writing by either approving or denying your claim.

For step four, you will then have 60 days to appeal your denied claim by writing to the Secretary of the Employee Benefit Plans Committee (EBPC), Mail Code 482- C26-A68, 300 Renaissance Center, P.O. Box 300, Detroit, MI 48265-3000. As part of this appeal, you must provide any written documentation to support your position that the Program provisions have not been properly applied. Requests for exceptions to the Program provisions may not be appealed to the EBPC.

Under the voluntary process, the EBPC of the Corporation has been delegated authority to construe, interpret, apply and administer the Program, and is the final review authority with respect to the appeal.

Effect of Medicare

Medicare is a federal health care program for individuals age 65 or older and for certain other individuals. Medicare has two parts: Part A, which provides hospital coverage and Part B, which provides medical coverage. Enrollment for Part A is automatic. Enrollment for Part B is voluntary and requires a monthly contribution, which you may have deducted from your Social Security check. ***It is your responsibility to contact the local Social Security Administration office to apply for Medicare***. It is suggested this contact be made three months prior to attaining age 65. This will allow sufficient time to process your application so you will not miss your initial opportunity for enrollment.

If you or one of your dependents have a severe long-term disability, end-stage renal disease, or undergo a kidney transplant, you may be eligible for Medicare coverage prior to age 65. If you or one of your dependents fit one of these categories, you should contact your nearest Social Security Administration office to have your case evaluated.

Generally, you or your dependents will want to enroll for Medicare when you first are eligible to do so. This is true not only because of penalties which may be incurred in Medicare premiums, but also because Medicare may cover services not covered by the GM Program. ***Moreover, eligibility for Corporation contributions for coverage may depend on Medicare enrollment. For example, in the event of your death, your surviving spouse will not be eligible for Corporation contributions for any GM health care coverages if your spouse is eligible, but is not enrolled, for Medicare Part B at or after age 65.***

If you are enrolled in Medicare, Medicare usually will be the primary source of benefits for you and your dependents who also are enrolled for Medicare. Benefits otherwise payable under the GM Program will be adjusted to reflect the amount of benefits payable by Medicare for the same covered services. The GM Program will supplement Medicare, to the extent the GM Program covers services Medicare does not cover. Your health care claim first must be filed with Medicare. After Medicare pays its portion, the claim should be sent to the appropriate GM carrier.

In some areas, arrangements have been made for Medicare to electronically submit claims to your GM carrier, after Medicare has paid its portion. This arrangement is called ***"Medicare Crossover"*** and may minimize your involvement in the claims handling process. ***You should contact your carrier to determine if Medicare Crossover is available in your area.***

Most health maintenance organizations (HMOs) accept Medicare enrollees; however, those plans generally require enrollment in both Part A and Part B, if eligible.

If you are enrolled in an HMO, you must follow the guidelines of the HMO regarding Medicare claims processing.

The Balanced Budget Act of 1997 made some changes in the Medicare program. The law includes a section called Medicare+Choice that creates new health plan options. All Medicare beneficiaries will receive annual mailings and information from the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers Medicare.

You should keep in mind that these mailings are not connected in any way with the GM Salaried Health Care Program. The Medicare materials will not explain how the changes apply to you and your Program coverage.

To continue your GM coverage, you will not need to do anything in response to the Medicare mailings. In fact, if you do join an HMO not offered by GM, or if you elect a plan outside the annual GM enrollment process, you may be putting your GM sponsored coverage at risk.

Medicare Primary – Example

Roger is a single 68-year-old salaried retiree who has elected the Enhanced Medical Plan. Roger is covered by Medicare; and because Roger is retired from GM and is not working for any other employer, Medicare is Roger's primary plan. Medicare has a $912 deductible for Part A hospital expenses and a $110 for Part B expenses.

Assume Roger is admitted into the hospital and that the deductible applicable to Roger's GM coverage has already been satisfied. Here is how benefits would be paid:

Hospital Expense	$3,900
Medicare Paid	2,988
Medicare Part A Deductible	$ 912

The Medicare Part A deductible amount is submitted to the GM Enhanced Medical Plan. Here is how benefits would be paid:

Medicare Part A Deductible	$912.00
Enhanced Medical Plan Pays 80%	$729.60
Roger Pays	$182.40

Credit applied to Roger's out-of-pocket limit under the Enhanced Medical Plan is $182.40.

Roger is now out of the hospital but must see his doctor for an evaluation. Assume the GM Enhanced Medical Plan deductible has been met as well as the Medicare Part B deductible. Here is how benefits would be paid:

Expense	$200
What the Enhanced Medical Plan would have paid if there was no other coverage	160
What Medicare Paid	160
What the Enhanced Medical Plan will pay	-0-

Because Medicare, as the primary plan, paid as much as what the Enhanced Medical Plan would have paid, no further payment will be made.

Credit applied to Roger's out-of-pocket limit under the Enhanced Medical plan is increased by $40.

Special Benefit

If you are enrolled in Medicare Part B and are a retiree or surviving spouse receiving a GM monthly Part A retirement benefit, you may be eligible to receive a monthly Special Benefit for each month you maintain Medicare Part B enrollment. The amount is equal to the ***lesser*** of the Medicare Part B premium or $76.20 and will be included in your monthly GM retirement check. Also, under current federal income tax law, because receipt of the Special Benefit is conditioned on your Medicare Part B enrollment as verified by GM, the Special Benefit will be non-taxable.

Retirees and surviving spouses who first became eligible for the Special Benefit prior to March 1, 1988 and who were receiving this Special Benefit but who were not enrolled in Medicare Part B on October 1, 1990 comprise a special group who are not required to enroll in Medicare Part B in order to continue receipt of a Special Benefit. However, these individuals receive only

$28.00 per month and the benefit is taxable. Retirees and surviving spouses in this special group may qualify for the increase by enrolling in Medicare Part B.

Evidence satisfactory to GM of your enrollment in Medicare Part B is required for you to receive a Special Benefit. If evidence of enrollment is not provided in a timely manner, retroactive payment of the Special Benefit will be limited to 12 months. Any recipient who is enrolled in Medicare Part B coverage will have the Special Benefit discontinued for periods during which Medicare Part B enrollment is not maintained.

The Special Benefit is ***not*** payable to any: (1) former employee receiving a deferred vested retirement benefit, (2) surviving spouse receiving a survivor benefit resulting from a deferred vested retirement benefit, or pre-retirement survivor benefit, or (3) a former employee who retired as a flexible service employee.

No more than one Special Benefit is payable to any individual for any one month.

Reimbursement for Third-Party Liability

Occasionally, a person may sustain an injury and incur health care expenses because of another party's wrongdoing. While GM does not suspend coverage while liability is being determined, GM should not bear the financial burden if another party is responsible. Consequently, if (1) GM pays benefits on behalf of you or one of your dependents, and (2) you recover any monies from a third party for the same expenses, you are expected to reimburse the Program.

You must provide notice to the Corporation (or to your health care carriers on behalf of the Corporation) of any such recovery (or effort to recover) from a third party. You are required to assist in the recovery effort. In this regard, you should note:

- The Corporation assumes your right to recover payment from any third party, up to the extent of such third party's liability;
- If you recover any monies through lawsuit, settlement, or other means, you must reimburse the Corporation for benefits paid;
- You grant the Corporation a lien on any monies you or your beneficiaries may recover, either through settlement or otherwise, whether the recovery is designated economic or non-economic damages;
- You grant the Corporation the right to intervene in a lawsuit for the purpose of enforcing the Corporation's lien;
- You grant the Corporation the right to recover its legal fees and costs that exceed the Corporation's payment of benefits from any recovery;
- You agree to inform the Corporation when you engage an attorney to pursue a claim, and to inform your attorney of the Corporation's rights under this Program; and
- You agree not to settle any claim or take any action that would prejudice the Corporation's rights or interests.

Relocating After Retirement...

If You Move...

- And you are enrolled in the Basic/Enhanced Medical Plan, because the Basic/Enhanced Plan is serviced by different carriers in different states, you must change to the carrier responsible for your respective state in order to properly facilitate claims processing. You will be reassigned to a new carrier automatically and may receive a new medical plan ID card once you change your address of record to reflect your move.

If You Reside In...

- ***Canada***
  U.S. retirees who are residents of Canada may elect to enroll for Optional Canadian Health Care Coverage (OCHCC). This is a permanent election as long as you remain a resident of Canada. You may re-enroll in the GM Salaried Health Care Program if you move from Canada.

  The OCHCC includes coverage for medical, dental, and vision services that supplements the Canadian National/Provincial coverage. It also includes an optional Comprehensive Medical Expense Insurance Program (CMEIP) component.

- ***Hawaii***
  Because of special provisions of federal and state laws, health care eligibility, coverages, and other provisions for employees residing in Hawaii differ from those applicable to other employees. **However, the provisions applicable to retirees or surviving spouses are the same as those applicable to retirees and surviving spouses residing elsewhere.**

More detailed information regarding the above provisions is available from the GM Benefits & Services Center.

Comparison of GM Health Care Program Coverages for U.S. Salaried Retirees and Surviving Spouses

Medical Plan Coverages	Basic Medical Plan (BMP)	Enhanced Medical Plan (EMP)	Preferred Provider Organization (PPO) (where available)	Health Maintenance Organization (HMO) (where available)
■ Hospital ■ Skilled nursing facility ■ Physical, functional occupational and speech therapy/cardiac rehabilitation coverage ■ Home health care coverage ■ Surgical and medical coverage ■ Ambulance service coverage	For the services listed, scope and level of coverage are identical for BMP, EMP, and PPO, subject to various plan limits.			
■ Prescription drug coverage (per prescription)	Retail: generic $5, preferred brand-name 25% with $15 minimum/$25 maximum, non-preferred brand-name $50 Mail order: generic $10, preferred brand-name $30, non-preferred brand-name $75 Must use the National Managed Pharmacy Network for full reimbursement.			Varies by HMO
■ Hearing aid coverage ■ Durable medical equipment/ Prosthetic and Orthotic appliance coverage (DME/P&O) ■ Hospice coverage	For the services listed, scope and level of coverage are identical for BMP, EMP, and PPO, subject to various plan limits.			
■ Mental health and substance abuse coverage	Scope and level of coverage are identical for BMP, EMP, and PPO and are subject to separate copayment provisions and limitations. Coverage is through CIGNA Behavioral Health.			
Extended Care Coverage (ECC)	Included with BMP, EMP, PPO, and HMO medical options			
■ Hospital ■ Skilled nursing facility ■ Nursing home ■ Home nursing ■ Custodial	■ Provides for certain long-term and/or custodial care needs, either not covered or that exceed medical plan limits ■ $50,000 maximum benefit per individual payable during any one calendar year			

Dental Plan Coverages	Traditional Dental Plan	Alternative Dental Plans (where available)
■ Preventive	100% Combined annual maximum benefit per individual of $1,700	Varies by Plan
■ Minor restorative	90%	
■ Major restorative	50%	
■ Orthodontics (under age 19)	50% $2,000 lifetime maximum per covered person	
■ Temporomandibular joint dysfunctions (TMJ)	50% ($2,000 lifetime maximum per covered person)	
■ Accidental dental injury	80% ($12,000 per qualified occurrence and per lifetime)	
Vision Plan Coverage	Vision examinations — Once during a calendar year Lenses — Once during a calendar year Frames — Once during two consecutive calendar years National Vision Network — There is no out-of-pocket expense for covered services when received from a participating provider. (Out-of-pocket expenses will be incurred if certain frames or lens features are selected.)	

Long-Term Care Insurance

The Long-Term Care (LTC) Insurance Plan is a welfare benefit plan that, if elected, provides long-term care insurance to salaried retirees, surviving spouses of salaried retirees, and their eligible spouses. LTC is designed to provide a degree of protection against the cost of care you might need if you were to require assistance from another person in caring for yourself as a result of an accident, illness, or effects of aging. It could provide benefits for a variety of services, including care in an assisted living facility, a nursing home, or adult day care setting as well as assistance with activities of daily living. The John Hancock Life Insurance Company of Boston, Massachusetts offers and underwrites the LTC Insurance. You are provided the opportunity to apply for coverage and remit payments to John Hancock. Participation is completely voluntary.

Who Can Apply?

Any of these individuals may separately apply for LTC Insurance:

- Eligible GM salaried retirees and their spouses (or qualified same-sex domestic partner);
- Surviving spouses of eligible GM salaried employees or retirees, and their spouses (or same-sex domestic partner).

John Hancock will notify you whether your application is approved or declined. Monthly LTC Insurance premium payments for you and/or your spouse (or same-sex domestic partner) are on a self-pay basis directly to John Hancock.

For the remainder of this section, the above groups will be referred to as “eligible applicants.”

GM’s Involvement

The involvement of General Motors is, without promoting the services, to allow the John Hancock Life Insurance Company to communicate features of their services to all salaried retirees. The LTC Plan is governed by ERISA. While GM is the sponsoring employer of the LTC Insurance, John Hancock is the claims fiduciary and:

- Is responsible for all payment of benefits;
- Is responsible for decisions regarding the payment of benefits;
- Is responsible for all decisions regarding the appeal of denied claims; and
- Has discretionary authority to interpret, apply, and construe the provisions of the plan with regard to claims issues.

GM does not guarantee and is not responsible for payment of any LTC benefits. The decision to purchase LTC Insurance is solely your responsibility. You should not interpret the availability of this option as a recommendation by GM for the purchase of it.

If you are covered by GM’s Salaried Health Care Program, you may have elected Extended Care Coverage (ECC). LTC is different from ECC. Although ECC and LTC insurance cover different services, in many instances there are services that are covered by both. If a service is covered by both, LTC may pay benefits over and above those payable by ECC. Additionally, each may pay benefits for services that the other does not cover. You can choose to have both ECC and LTC, decide to have only one of them or neither of them.

Types of Services

LTC Insurance covers an assortment of services, as follows:

- All levels of nursing home care — skilled, intermediate, and custodial — provided in a licensed nursing home or skilled nursing facility;

- Care provided in an assisted living facility to individuals with organically-based brain disorders. An assisted living facility must be licensed to provide residential care specifically to people who have Alzheimer's disease or other forms of dementia;

- A temporary bed-holding benefit. This holds a bed in a nursing home or assisted living facility for up to 10 days if the insured should have to go into a hospital while receiving plan benefits;

- An alternate plan of care if it is recommended and approved by a Care Manager at John Hancock and it appears to be more cost effective and appropriate. For example, payment could be approved to have a doorway to the bathroom widened to improve wheelchair access, so that an insured person could remain at home instead of having to go into a nursing home;

- The following home health care services:
  - Care provided by a registered nurse, licensed practical nurse, or licensed vocational nurse;
  - Services provided by a qualified home health aide for the purpose of assisting in activities of daily living;
  - Physical, respiratory, occupational, or speech therapy provided by a licensed therapist;
  - Nutrition counseling provided by or under the supervision of a registered dietitian;
  - Services provided by a registered nurse, physician's assistant, or medical social worker in evaluating the need for and development of a home health care plan upon request of an attending physician;

Home health care services provided by a family member or by a person who ordinarily lives in the insured's home are not covered.

- Adult day care, including a range of medical and support services provided by a qualified adult day care center;

- Informal care by a licensed or unlicensed caregiver, including a family member who does not ordinarily live in the insured's home. Covered services include:
  - Assistance with activities of daily living, such as bathing or dressing;
  - Maintenance of the home environment through the following services: shopping, menu planning, meal preparation, and light housekeeping;
  - Personal supervision for the protection of a cognitively impaired person.

Informal care services provided by a person who ordinarily resides in the insured's home are not covered.

The plan also pays benefits when nursing home care, skilled nursing care, home health care, adult day care, or informal care is needed for respite care. Respite care is short-term care that provides temporary relief to a family member or other informal caregiver.

Coverage Options

Three levels of Daily Maximum Benefit amounts are available. These options represent the maximum daily amount and the corresponding Lifetime Maximum Benefit amount the plan will pay for covered care in a nursing home, skilled nursing facility or assisted living facility.

Home health care, adult day care, and informal care are also covered under the plan. The maximum benefit for each covered day of home health care and/or adult day care is 60% of the nursing home Daily Maximum Benefit. The maximum benefit for each covered day of informal care is 25% of the nursing home Daily Maximum Benefit. The

total of benefits payable for all informal care received in any calendar year is 30 times the informal care daily maximum benefit.

The Lifetime Maximum Benefit is the most the plan may pay for all covered expenses. Think of it as a pool of money against which benefits may be drawn — according to the schedule of benefits for the option elected.

For individuals whose coverage begins on or after January 1, 2005, the available options are as follows:

	Nursing Home/Assisted Living Facility Daily Maximum Benefit*	***Home Health Care/Adult Day Care Daily Maximum Benefit****	***Lifetime Maximum Benefit***
Option 1	$ 85	$51	$160,000
Option 2	$115	$69	$210,000
Option 3	$170	$102	$315,000

* *Due to differences in state regulations, the options for residents of Connecticut, Delaware and Kansas are slightly different and can be obtained by calling John Hancock directly at 1-800-200-6773.*

When Benefits Are Needed

When an insured person needs long-term care services, the GM Medical Plan and Extended Care Coverage should be reviewed in addition to calling John Hancock Long-Term Care Customer Service Center. The John Hancock Care Manager, a registered nurse with extensive knowledge in the long-term care field, will determine whether the insured qualifies for Long-Term Care benefits.

The insured person will be certified for benefits when a Care Manager determines him/her to be cognitively impaired or dependent in at least two of five Significant Activities of Daily Living (***SADLs***), due to a covered condition. The insured person will be eligible for benefits after completing a 90-day qualification period. ***Kansas residents must meet slightly different requirements; call John Hancock at 1-800-200-6773 for details.***

Cognitively Impaired

A person is cognitively impaired if he/she has a deterioration or loss of intellectual capacity due to an organic brain disorder that requires continual supervision for the protection of the person or others. Alzheimer's disease is an example of an organic brain disorder.

Dependent in a Significant Activity of Daily Living SADL

For purposes of LTD a person is dependent in a SADL if he/she needs help or supervision from another person to perform a major part of a SADL a majority of the time. The five SADLs are:

- Bathing or dressing;
- Eating;
- Maintaining continence;
- Toileting; and
- Transferring from bed to chair.

The Care Manager considers the person's cognitive and physical ability to perform these activities independently, safely, and appropriately without supervision or help. For example, if the insured can't bathe or eat without help or supervision from another person, he/she will be certified as dependent in these activities.

Your Care Manager will:

- Assess long-term care needs;
- Determine level of cognitive impairment, or dependence in the Significant Activities of Daily Living for certification to receive benefits;
- Suggest types of facilities or care providers most suited to the situation; and
- Research and provide a list of long-term care resources for you and your family.

Qualification Period

A claimant must complete a 90-day qualification period before being eligible for benefits. The qualification period starts on the date the person is determined to be SADL-dependent or cognitively impaired and ends 90 days later, as long as the person stays certified during this time. The person doesn't have to receive long-term care services or be hospitalized at any time during this period. The plan will pay benefits for covered charges incurred after the qualification period is met, as long as the person remains certified. ***Benefit payments are determined by John Hancock in accordance with the terms of the policy.***

Waiver of Premium

Once a person becomes certified for plan benefits and has satisfied the qualification period, premium payments are suspended. The claimant will not need to make any further premium payments until he/she is no longer certified. This payment "break" is known as a waiver of premium.

Exclusions

To keep your coverage more affordable, some exclusions apply. No benefits will be payable for services received due to the following conditions and circumstances:

- Mental or emotional disorders without demonstrable organic disease. This includes, but is not limited to, neurosis, psychoneurosis, psychopathy, and psychosis. This exclusion does not apply to Alzheimer's disease or other organically caused brain disorders;
- Intentionally self-inflicted injury;
- Treatment specifically provided for detoxification or rehabilitation of alcoholism or drug abuse;
- Conditions caused by:
  - Committing or attempting to commit a felony;
  - Engaging in an illegal occupation;
  - Participating in an insurrection or riot;
- Conditions caused by war, declared or not, or any act of war, or service in any armed forces or auxiliary units;
- Care or treatment provided outside the United States or Puerto Rico. (The United States includes only the 50 states and the District of Columbia.);
- A service or supply furnished primarily to beautify;
- A service or supply furnished by or covered as a benefit under a program of any government or its subdivisions or agencies, except:
  - A program established by the federal government for its civilian employees,
  - Medicare, and
  - Medicaid (any state medical assistance program under Title XIX of the Social Security Act as amended from time to time); and
- A service or supply for which a charge would not have been made in the absence of insurance.

These exclusions may not apply in all states, and may vary depending on the state in which you live. The Certificate of Insurance you receive once you are insured will outline the exact exclusions for your state. If you move to another state, the state guidelines where the Certificate of Insurance was originally delivered to you will apply.

Important Information

Notice

This is only a summary of the Long-Term Care Insurance available; it does not cover all the details. The Certificate of Insurance that is issued to you when you become insured contains the detailed statement of the terms and conditions of your insurance coverage. If there is any conflict between the information contained herein and the Certificate of Insurance, the terms of the Certificate will control.

LTC is offered through an insured policy issued by John Hancock to GM. John

Hancock is solely responsible for payment of benefits in accordance with the terms of the policy. GM does not guarantee and is not responsible for payment of any LTC benefits.

Please note that plan provisions may be changed or deleted in order to satisfy state requirements or other legal requirements. General Motors reserves the right to discontinue or change these benefits at any time. In the event that benefits are changed, except to comply with legal requirements, John Hancock will allow existing insureds to continue their coverage. In the event the group policy is terminated or the LTC plan is discontinued, existing insureds may continue their coverage under a replacement policy or under a conversion policy issued by John Hancock.

Coverage is provided under Policy #28201-LTC issued on form GPB-COV-0002 to General Motors Corporation and underwritten by John Hancock Life Insurance Company.

Review of Denied Claims

If your claim for benefits under your Long Term Care Insurance Policy is denied, in whole or in part, you or your authorized representative will receive a written notice giving the reason for the denial. You will then be entitled to a review of that claim denial if:

- You make written request for such review; and
- You send such request to John Hancock within 60 days after receipt of the denial.

In your request for a claim review, you should:

- state why you disagree with John Hancock's determination;
- state what other factors (if any) John Hancock should take into consideration; and
- identify whom John Hancock could contact (including names, addresses, and phone numbers) to gather any additional pertinent information regarding your condition or your care.

John Hancock will make a full and fair review of the claim and may require additional information to objectively evaluate your appeal. John Hancock may use one or more of the following resources for its review:

- a Physician who will assess your condition and report it to John Hancock;
- an on-site geriatric assessment; or
- medical records from your physician(s) and/or provider(s) of care.

John Hancock will then review and make a final decision with respect to the claim appeal for benefits under the Policy. In reviewing your claim John Hancock will have discretionary authority to interpret, construe and apply the terms of the Long-Term Care insurance. The decision will be in writing and, if a denial, will include specific reasons for the denial. John Hancock will make its decision regarding your claim promptly, and usually not later than 60 days after receiving the request for review.

For More Information

If you have any questions about enrollment, the LTC Insurance Plan or long-term care in general, please call John Hancock at ***1-800-200-6773.***

Your GM Investments

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Your GM Investments

Your savings and GM's matching contributions in the Savings-Stock Purchase Program (S-SPP) may represent a substantial portion of your retirement savings. While you may be retired from work, your money isn't — it has to keep working as hard as ever. During retirement, your investment goal should be to ensure that your savings last long enough to keep you living in comfort for the rest of your life. The S-SPP provides you the flexibility to continue to manage your account in retirement in order to help you meet your financial needs.

Deferral of S-SPP Assets at Retirement

At retirement, if the value of your S-SPP assets is greater than $ 1,000, you may defer continuously the receipt of your assets. Such a deferral would allow your assets to continue to grow, on a tax-deferred basis, while they remain in the Program. If you defer the distribution of your account, you may elect subsequently to receive your S-SPP assets in a lump sum at any time. Moreover, you may continue to "manage" the assets in your account while they remain in the Program.

During the time your assets remain in the Program, you will be furnished an account statement every three months showing the assets in your account.

Access to Your S-SPP Account

As a participant in the Program, you must establish, through the GM Benefits & Services Center, a confidential Personal Identification Number (or PIN) which is known only to you. This confidential PIN limits access to your S-SPP account to you only. You may, at any time, change your PIN. Moreover, you may only access your own account information and initiate transactions by telephone, or the Internet, using your confidential PIN and social security number or Customer ID (a Customer ID is an identifier you create to use in place of your Social Security number). ***You should not give anyone your PIN.***

Investing in the S-SPP Options

A complete listing of the investment options currently available under the Program is contained in the S-SPP prospectus. Furthermore, a detailed description of each of the Promark Funds and the GM $1-2/3 Par Value Common Stock Fund is contained in the S-SPP prospectus. A detailed description of the Fidelity and other mutual funds is included in the individual mutual fund's prospectus. **Before you invest in a fund, please read the relevant prospectus for the fund.** Prospectuses may be obtained from the GM Benefits & Services Center by either calling 1-800-489-4646 or accessing the S-SPP website at gmbenefits.com.

As a Program participant, ***you are solely responsible for the selection of your investment options.*** When making your investment decisions, you are assuming the risks of potential losses, which may result from your decisions. GM and/or any of its agents are not empowered to advise you as to the manner in which your investments should be made. Additionally, the fact that an option is available for investment under the Program should not be construed by you as a recommendation by GM for investment in that option.

You should note that the market value and the rate of return on each investment option fluctuates over time and in varying degrees. Accordingly, the proceeds, if any, you realize from such investments depend on the prevailing market value of the investments at a particular time, which may be more or less than the amount you invested initially. There is no assurance that any of the investment

options will achieve their objectives or your objectives. Each investment option is subject to varying degrees of risk that are discussed in the Program's prospectus.

If you elect to invest in any of the Fidelity and other mutual funds, you are responsible for obtaining and reading the prospectus for each mutual fund in which you are considering investing. Each mutual fund prospectus contains information on the fund's objectives, risks, fees, exchanges, redemptions, securities lending, and the use of derivatives. Certain Fidelity mutual funds carry a sales charge (load); however, these charges are waived for Program participants.

Some Fidelity mutual funds, typically those whose securities have high trading costs, may impose a redemption fee if an investment is held for less than a stated period (this fee is paid to the mutual fund and protects the funds performance and shareholders by discouraging frequent trading in response to short-term market fluctuations). If applicable, such fees are disclosed in the individual Fidelity mutual fund prospectuses.

Fund Exchanges

During the time your assets remain in the Program, you may exchange assets in 1% increments or whole dollar amounts among the various investment options as permitted under the Program. An exchange must consist of assets having a current market value of $500, or, if less, all the assets in the Fund.

You may initiate an exchange on any day the New York Stock Exchange (NYSE) is open for business during the year, by contacting the GM Benefits & Services Center. Exchanges are effective the day of your request, provided you initiate the transaction before the close of business of the NYSE, normally 4:00 p.m. Eastern time. Exchanges initiated after the close of business of the NYSE or on a weekend or holiday observed by the NYSE will be effective on the next business day.

GM reserves the right to modify or suspend subscriptions, redemptions or exchanges involving any one or more of the Promark Funds or the GM $1-2/3 Par Value Common Stock Fund offered under the Program, at any time, in response to market conditions or otherwise. Furthermore, Fidelity and the other mutual fund providers reserve the right to modify or suspend exchanges among their mutual funds as described in their prospectuses. Fidelity and the other mutual fund providers also reserve the right, under circumstances described in their prospectuses, to suspend or delay purchases and/or redemptions from their mutual funds, which might in turn delay your exchanges to or from Promark Funds or the GM $1-2/3 Par Value Common Stock Fund.

Loans

You may borrow from your S-SPP account assets after you retire. You may only take one loan each calendar year and may have up to five outstanding loans at any one time. The loan may be for any reason. No credit statement is required. Amounts borrowed are not subject to income tax, except in the case of a loan default. If you are the surviving spouse of a participant and you have assets in the Program, you may also take a loan from your account.

The minimum loan amount that you may borrow is $1,000. You may not have at any time loans outstanding exceeding the maximum of $50,000. You may apply for a loan for an amount that is the lesser of:

- $50,000 less the highest amount of loans you had outstanding during the prior 12 months; or
- One-half of the current market value of your total vested assets.

The interest rate payable on a loan is the prime interest rate prevailing as of the last business day of the quarter immediately preceding the date that a loan is requested. The prime rate is the rate charged to a bank's best customers. The interest rate will remain fixed for the duration of a loan.

Cash for your loan is obtained by selling assets in your account. You may choose which assets to sell. For example, you may request that assets in a particular investment option be sold, or you may select multiple options. If you do not indicate a choice, a pro-rata amount of the assets in your account will be sold.

The minimum loan repayment is $50 per month, over a period of time you elect. Generally, the repayment period ranges from six months to five years. You have up to 10 years if the loan is to purchase or build your principal residence. There are no prepayment penalties if you repay the loan earlier than scheduled.

Amounts repaid are allocated to your S-SPP account based on the investment option(s) you elect for your discretionary contributions. Although, as a retiree, you are ineligible to contribute to the Program, your loan repayments will be allocated according to your last discretionary contribution investment election on file. For some, this election has been on file since you last contributed to the Program; therefore, this election may not reflect your current investment desires. To change your discretionary contribution investment election for your loan repayments you should contact the GM Benefits & Services Center. If there is no discretionary contribution investment election on file, any loan repayments you make will be allocated to the Promark Income Fund until you make such an election.

Loan repayments will not be deducted from your GM retirement checks. Any S-SPP loans you take must be repaid by making monthly cash payments. The GM Benefits & Services Center will send you loan repayment coupons when your loan is approved.

In the event you fail to make a required loan payment and your failure to make such loan payment continues beyond the last day of the calendar quarter following the calendar quarter your required loan payment is due, your loan shall be considered in default and you shall be irrevocably deemed to have received a distribution of assets in an amount equal to the outstanding balance of the loan, plus any accrued interest, calculated to the date the loan is deemed distributed. Prior to defaulting on an outstanding loan, a notice will be sent to you providing you with repayment opportunity ***unless*** the failure to repay the loan is a result of your bankruptcy. Please note, defaulting your outstanding loan balance may result in tax consequences for you.

Installment Payments and Partial Distributions

You may elect to receive your assets in periodic installment payments from the Program, provided you defer your distribution at retirement. Installment payments may be made on a monthly, quarterly, semi-annual or annual basis. Installments must be in whole dollar amounts and total at least $1,200 each year. You may, at any time, revise the amount and frequency of any such installments, or you may discontinue installment payments.

The amount you elect for installment payments shall be obtained pro-rata from each fund in your account in the following order: (1) assets obtained with Regular Savings, (2) assets obtained with rollover contributions, Corporation contributions, and Deferred Savings.

Additionally, you may take a partial distribution of your assets at any time, either in addition to any installment payments you may elect or without installment payments.

Age 70-1/2 Minimum Distribution Requirement

If you (1) defer receipt of your S-SPP assets and (2) later attain age 70-1/2 and continue to have an account balance, federal law requires that you must receive annually a minimum required distribution from your account. The first such minimum distribution payment will be made to you automatically,

in December of the year in which you attain age 70-1/2, unless you elect to defer receipt of your first minimum distribution payment until no later than April 1 of the following year. Thereafter, depending upon the amount you withdraw voluntarily during the year from your S-SPP account, a minimum distribution payment will be made to you in December each year.

When a minimum distribution is required from your S-SPP account this requirement will be satisfied in one of two ways. First, absent any installment or partial distribution(s) from your account in the year, a distribution equal to the minimum required amount will be paid to you in December of the year. Second, the cumulative amount of any voluntary (1) installment distribution(s) and (2) partial distribution(s) that you take from your account during the year will first be used to satisfy the legally required minimum amount applicable for such year. The amount of any such payment will be based upon your (1) account balance and (2) remaining life expectancy, unless you elect to have the payment based upon both your life and your S-SPP beneficiary's life expectancies. You will be notified, in writing, prior to receipt of your initial minimum required distribution.

Tax Considerations

All or a portion of a distribution from the S-SPP is taxable to the extent the value of your distribution exceeds your unused Regular Savings after-tax basis. In addition to ordinary income tax, under current tax law, a 10% additional early distribution tax will be imposed on the taxable portion of any Program distribution made when you are under age 59-1/2.

The additional tax does not apply to (1) the nontaxable return of your Regular Savings, or (2) taxable monies you roll over, or elect to have directly rolled over, into an IRA or another qualified plan. Moreover, the 10% tax does not apply to distributions that are:

- Made to you after you separate from service by retirement during or after the calendar year in which you attain age 55;
- Made to you because you have tax-deductible medical expenses (whether or not you itemize deductions);
- Paid to an alternate payee under a Qualified Domestic Relations Order;
- Made to you because you received a federal tax levy after 1999;
- Paid to your beneficiary after you die;
- Made to you because you are totally and permanently disabled; or
- Made to you as part of a series of substantially equal periodic (at least annual) payments over your lifetime or the joint lives of you and your beneficiary and such payments begin after your separation from service and continue for five years or until age 59-1/2, whichever is later.

If you have an outstanding S-SPP loan and the loan balance is not repaid before you take a lump-sum distribution, it will be included, for tax purposes, as part of your lump-sum distribution.

Under current tax law, if you were at least age 50 on January 1, 1986, special averaging rules may apply on your lump-sum distribution. Under these special averaging rules, you may make a one-time election at any age to use capital gains treatment and/or 10-year income averaging under 1986 income tax rates.

As an alternative to receiving a distribution, you can elect a "direct rollover" of all, or any portion, of the taxable amount of your S-SPP distribution into an IRA, or another qualified plan. If you do this, under current tax law, you would pay no tax at the time of distribution on the amount rolled over. However, if you choose to have all, or a portion, of your S-SPP assets paid to you, federal income tax will be withheld at a mandatory rate of 20% on the taxable amount of the distribution. If, after you receive your S-SPP distribution, you decide to roll over

100% of the taxable amount of such distribution into an IRA, or another qualified plan, you must provide the funds to replace the 20% that was withheld. This tax-free rollover must be accomplished within 60 days after your receipt of the distribution. Any amount rolled over will not be taxed under current tax law until you withdraw it from the IRA, or another qualified plan. However, any amounts withdrawn from an IRA at a later date would be subject to tax at ordinary income tax rates.

The tax rules governing distributions are complex and may vary depending upon the facts of each case. Therefore, ***prior to electing a distribution from the S-SPP, you should consult with your personal tax advisor to determine the tax consequences.***

Qualified Domestic Relations Order (QDRO)

Following is the address/phone number where participants can obtain information, without charge, about QDRO procedures.

Savings-Stock Purchase Program
GM Benefits & Services Center
FIIOC – QDRO Administration Group
P.O. Box 770003
Cincinnati, OH 45277-0066

Telephone Number: 1-800-489-4646 or 1-877-347-5225 TTY.

Ayco Financial Planning

All of the Following Information Regarding Ayco Financial Planning is provided by Ayco.

Options

- No coverage
- Money In Motion® Personal Finance Program for Retirees

Contributions

For information or to enroll, call Ayco directly at 1-800-437-6383, Monday through Friday between the hours of 9:00 a.m. and 5:00 p.m. Eastern Time zone.

Election Rules

Financial planning is available only to U.S. residents, International Service Personnel and residents of Puerto Rico.

Features

Real-world personal guidance for all major life events plus analytical tools for the "do-it-yourselfer."

The Personal Finance Program for Retirees provides access to an experienced, objective financial planner via the toll-free *Ayco AnswerLine*Ò service, as well as the interactive power of the Ayco Financial Network (www.aycofn.com), a password-protected, member-only website that acts as your financial mentor and record-keeper. Through *The Ayco AnswerLine*Ò, you can get personalized, professional advice on planning issues of specific interest to retirees, like setting an estate plan, reallocating your portfolio, or increasing your cash flow. Personalized, topic-specific reports provide an objective assessment of your current financial situation (including stock option planning).

Aycofn.com provides “do-it-yourselfers” with the tools they need to assess their financial health and prioritize while guiding them through the steps they need to take. It allows users to keep a secure, easily updatable record of their progress and features a variety of financial modeling tools. You can model multiple scenarios as life events occur and access Ayco’s online reference library for information on cash flow, debt management, investments, estate planning, insurance, tax planning and key life events.

Using Aycofn.com in conjunction with an *AnswerLine*Ò planner can help you make better informed decisions and avoid costly

mistakes in today's complex financial environment.

About Ayco

The Ayco Company (a wholly owned subsidiary of the Goldman Sachs Group, Inc.) is widely recognized as one of the nation's foremost fee-based (i.e., objective) financial counseling firms, and provides comprehensive financial planning services to employees at over 300 major corporations. Ayco's financial planners are not salespeople, and its services are not sales programs. Most of Ayco's financial planners hold credentials such as a law or MBA degree - or a CPA or CFP certificate. All are required to hold NASD securities licenses, and all participate in Ayco's internal training and continuing education programs.

What the Personal Finance Program includes:

- "Welcome Letter" and brief confidential questionnaire that helps Ayco understand your planning needs
- Personalized financial counseling via The Ayco *AnswerLine*Ò service (up to five hours annually)
- Ayco's *Updates* newsletters (10 issues)
- The *Ayco-Approved List of Mutual Funds*
- Access to personalized Focus Reports on retirement, asset allocation and education funding
- Unlimited access to the Ayco Financial Network
- The *Investing in Your Future* guidebook, a comprehensive planning reference

Considerations

This service is designed to be meaningful to all GM salaried employees, at any stage of their lives.

The service includes five hours of telephone access to Ayco financial planners familiar with GM's benefit plans. Ayco's consultants will provide information on a broad range of topics including tax withholding, investment allocation, life insurance analysis and estate planning.

For More Information About the Financial Planning Option

- Call Ayco's Customer Service Line at 1-800-437-6383, Monday through Friday, 9:00 a.m. to 5:00 p.m. Eastern time (1-518-464-2488 if calling from outside of the United States)
- Visit Ayco's website at www.aycofinancialnetwork.com/clients/mim for more information on the *Ayco Financial Network*Ô and the other services available to GM employees

Your Life and Disability Benefits

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Your Life and Disability Benefits

If You Are Disabled

If you were disabled at the time you retired, you may be receiving extended disability benefits (or supplemental extended disability benefits, if applicable) under the Life and Disability Benefits Program. If you are totally and permanently disabled and last worked prior to January 1, 1974, you may have received, or may be receiving, an installment payout of your basic life insurance. The benefits available to you are those provided under the Program in effect when you last worked for GM.

If you retired under the total and permanent disability provisions of the Retirement Program, your retirement benefits are discussed on page 10. If you become disabled after you retire, your type of retirement will not change, but you may have changes in your retirement benefits as discussed on pages 8 – 10.

Set forth below are answers to questions you may have concerning extended disability and total and permanent disability benefits that may be payable under the Life and Disability Benefits Program. If you have a specific question about extended disability benefits or a monthly installment payment of basic life insurance that is not answered here, you may wish to contact the GM Benefits & Services Center at 1-800-489-4646 or 1-877-347-5225 (TTY).

Extended Disability Benefits

Receipt of Extended Disability and Continued Eligibility

You must submit proof of your continuing disability as requested by the GM Benefits & Services Center.

If you last worked on or after January 1, 1974, you must be totally and continuously disabled so as to be unable to engage in any regular employment with GM at the location where you last worked, and must not be working elsewhere. If you last worked on or after January 1, 1968, but before January 1, 1974, you must be totally and continuously disabled so as to be unable to engage in any gainful occupation or employment for which you are reasonably qualified by education, training or experience, and must not be working elsewhere.

The Maximum Period for Extended Disability Benefits to Be Payable

If you continue to be disabled (as just described), monthly extended disability benefits are payable until recovery, or, if less, for a period equal to your years of participation under the Life and Disability Benefits Program at the beginning of your disability, less the period for which you received sickness and accident benefits or salary continuation payments. If you last worked on or after January 1, 1974, and had 10 or more years of participation at the beginning of your disability, monthly extended disability benefits can be payable to age 65.

Extended disability benefits generally are not payable beyond age 65. However, if you (1) last worked on or after January 1, 1979, but prior to November 1, 1987, (2) become disabled at or after age 63, and (3) become eligible for extended disability benefits, benefits are payable up to 12 months, but not beyond age 70. If you (1) last worked on or after November 1, 1987, (2) become disabled at or after age 63, and (3) become eligible for

extended disability benefits, benefits are payable for a period of six to 12 months.

If your service date is on or after January 1, 2001 and you have six or more years of service when you become disabled, benefits are payable until recovery, death or for a maximum of 5 years whichever comes first.

If your service date is on or after January 1, 2001 and you have less than six years of service when you become disabled, benefits are payable until recovery, or, for a period equal to your years of service at the commencement of disability (less the period during which sickness and accident benefits or salary continuation payments are received).

Determination of Extended Disability Benefit Amount

Your monthly extended disability benefit amount is 60% of your monthly base salary (as defined under the Program) in effect at the time you last worked prior to becoming disabled (50%, if you last worked before January 1, 1974).

Extended disability benefits are reduced by any Part A benefits and Part B supplementary benefits (see pages 8 – 10) for which you are eligible under the Retirement Program and by any benefits for which you are eligible under any other GM retirement or pension plan. In addition, governmental benefits such as workers' compensation, certain Social Security benefits, or any federal or state lost-time disability benefits are deductible. Increases in your governmental benefits, or any increase in your retirement or pension benefits payable after September 30, 1976, after extended disability benefits commence, will not be deducted. However, if the increase represents an adjustment in the original determination of the amount of such benefit, the increase will be deducted. A retroactive award of any of these benefits will create an overpayment of extended disability benefits that were paid for the same period of disability. You will be required to repay any such overpayment.

Effect of Social Security Entitlement on Extended Disability Benefits

Monthly extended disability benefits are reduced by Social Security disability or Retirement Insurance Benefits to which you may be entitled for the same period. Extended disability benefits are not reduced for receipt of Retirement Insurance Benefits reduced because of the age at which received.

Social Security Disability Insurance Benefits

It is important for you to apply for Social Security Disability Insurance Benefits for these reasons:

- Failure to claim a Social Security disability award may result in a lesser Social Security Retirement Insurance Benefit;
- Your dependents also may qualify for Social Security benefits;
- Your Social Security benefits may be increased annually to reflect cost-of-living increases. These increases are not deducted from your extended disability benefits;
- You become eligible for Medicare after 24 months of Social Security Disability Insurance Benefits; and
- Social Security disability awards are given favorable federal tax treatment, under current tax law.

If You Are Receiving Extended Disability Benefits and Become Eligible for Social Security Benefits

You should immediately submit a copy of the notice you receive from Social Security that tells you the amount of benefits and the date you became eligible, to:

GM Benefits & Services Center
P.O. Box 770003
Cincinnati, OH 45277-0066.

This notice is necessary to avoid an overpayment of extended disability benefits which you would have to repay. Notification also is necessary to provide you with additional benefits if your benefits have been reduced by a presumed amount of Social Security that is greater than the amount of Social Security to which you actually are entitled.

If You Receive a Social Security Award That Provides Benefits for a Period for Which You Have Already Received Extended Disability Benefits, It May Affect Your Extended Disability Benefits

If extended disability benefits have been overpaid, you will be required to repay General Motors. Any overpayment may be recovered by reducing your future monthly extended disability benefits or any other benefits payable to you under a GM benefit plan, or by your direct payment to the extended disability benefits administrator. You will be notified of the amount to be repaid.

If you wish, you may direct GM to withhold an amount up to 10% of your monthly retirement benefit to repay any extended disability benefit overpayment.

If extended disability benefits have been reduced by a presumed amount of Social Security, and the amount of Social Security you actually receive is less than the amount deducted, you will receive an additional amount from GM.

Benefit Payable to Beneficiary When Receiving Monthly Installments of Basic Life Insurance

If you last worked prior to January 1, 1974 and received (or are receiving) an amount equal to your basic life insurance in installments, a benefit of $500 will be payable to your beneficiary (or beneficiaries) at the time of your death. If you die before receiving all of the installments, your beneficiary (or beneficiaries) would receive the unpaid balance, but in no case less than $500.

If you last worked on or after January 1, 1974 and prior to January 1, 1994 and you received (or are receiving) an amount equal to your basic life insurance in installments, your beneficiary will receive the balance of any unpaid installments. If all installments have been paid to you, no benefits are payable upon your death.

Continued Disability Eligibility

You may be asked to be examined by a doctor, clinic, or other medical authority for the purpose of verifying disability at any time you may be eligible to receive extended disability benefits or a monthly installment payment of basic life insurance. Generally, if you are found to be able to work, your benefits will be discontinued. Failure to report for the examination may affect your eligibility for benefits. You will be reimbursed, upon request, at 36¢ per mile, for travel to and from the examination if your residence is more than 40 miles (one-way) from the examiner's office.

Accelerated Benefits Option

If you are diagnosed as having a terminal illness with a life expectancy not to exceed 12 months, you may be eligible to receive an accelerated benefits option payment of up to 50%, but not less than $1,000, of your basic life insurance. However, if your basic life insurance will be reduced within 12 months of the date the accelerated benefits option payment is approved, such payment will be limited to 50% of the fully reduced amount of basic life insurance.

The total of an accelerated benefits option payment and the amount of basic life insurance payable at your death may never exceed the amount of basic life insurance which would otherwise have been payable without the accelerated benefits option payment.

An accelerated benefits option payment will be made (1) as of the date the insurance company certifies all eligibility requirements are met, (2) only once, regardless of the amount elected, (3) only in one lump sum and (4) only if you are living when payment is made.

An accelerated benefits option payment will be reduced by any benefits paid to you under any GM benefit plan which should not have been paid or should have been paid in a lesser amount.

An accelerated benefits option payment will not be made if (1) your basic life insurance is not in force, (2) you are making contributions for basic life insurance, (3) all or a portion of your basic life insurance is to be paid to a former spouse/same-sex domestic partner and/or child(ren) as part of a divorce agreement, (4) the amount of payment would be less than $1,000, (5) you previously received payment of basic life insurance as an accelerated benefits option, regardless of the amount paid, (6) you are not living as of the date the insurance company certifies all eligibility requirements are met, or (7) you have assigned all or a portion of your basic life insurance to another party.

You may be required to be examined by a physician or physicians designated by the insurance company, at the insurance company's expense, for the purpose of determining if you are terminally ill and have a life expectancy not to exceed 12 months.

After you die, basic life insurance proceeds payable to your beneficiary (or beneficiaries) will be reduced by the amount of any accelerated benefits option payment.

To apply for an accelerated benefits option payment, you will be required to complete a claim form provided by the ***GM Benefits & Services Center.*** A form may be obtained by calling the GM Benefits & Services Center toll-free at ***1-800-489-4646*** or, for the hearing/speech impaired, ***1-877-347-5225***.

Disqualification, Ineligibility, Denial, Loss, Forfeiture, Suspension, Offset, Reduction or Recovery of Benefits

The following circumstances may result in disqualification, ineligibility, denial, loss, offset, suspension, reduction or recovery of benefits. The circumstances include but are not limited to: insufficient length of service; insufficient credited service; Impartial Medical Opinion Examinations; offsets due to Social Security, workers' compensation, and retirement benefits; failure to comply with program eligibility rules; falsification of disability claim forms; gainful employment; termination of the plan; any benefit plan overpayments due to any reason; and end of continuance period; and state of residence.

Your Life and Disability Benefits

Continuance of Your Life Insurance

The basic life, optional life, dependent life, and personal accident insurance coverages shall be administered in compliance with applicable state laws to the extent legally required and to the extent such laws are not preempted by federal law.

If your service date is after January 1, 1993, basic life insurance ceases upon retirement. If your service date is on or after January 1, 2001, you are not eligible to continue optional, dependent, and personal accident insurance coverages post-employment.

The benefits available to you and your eligible survivors are those provided under the Life and Disability Benefits Program in effect when you last worked for General Motors.

Basic Life and Extra Accident Insurance

Basic Life and Extra Accident Insurance as a Retiree

Depending upon when you last worked, you may have all, or a portion, of your basic life insurance continued during retirement before age 65, without cost to you. However, if you retired voluntarily as early as age 55 and prior to age 60, when combined years of age and credited service totaled less than 85, you must contribute until age 65, at a rate of $.50 per month for each $1,000 of basic life insurance in force.

Basic life insurance is not continued (1) if you received a monthly installment payment of basic life insurance because of total and permanent disability (as described on page 79), or (2) if you were hired on or after January 1, 1993.

Extra accident insurance is continued to age 65, while basic life insurance is in force, if you last worked prior to July 1, 1985.

Continuing Life Insurance Provisions (Applicable to Employees Who Retire While Insured)

If your most recent date of hire (or adjusted service date) was on or after January 1, 1993, your basic life insurance ceased upon retirement. However, you were allowed 31 days following the date of cessation of insurance to convert your insurance to an individual policy without proof of good health.

If your most recent date of hire (or adjusted service date) was prior to January 1, 1993, and you last worked on or after January 1, 1994 (and you retired other than for total and permanent disability), the amount of your basic life insurance was reduced immediately upon retirement to an amount equal to 1-1/2% for each year of participation times the amount of life insurance in force at retirement.

If you retired as totally and permanently disabled, your basic life insurance reduces at age 65.

Example...

Assume you retired in 1995 (for reasons other than total and permanent disability) with 30 or more years of participation and basic life insurance in the amount of $80,000. Your basic life insurance would have reduced immediately to $36,000 upon retirement as follows:

1-1/2% x 30 = 45%
45% x $80,000 = $36,000

If your most recent date of hire (or adjusted service date) was prior to January 1, 1993 and you last worked on or after July 1, 1985 and prior to January 1, 1994 and you retired other than for total and permanent disability, your basic life insurance reduces by 2% each month on the earlier of age 65, or retirement. This reduction continues until the amount of insurance equals the amount in force when insurance begins to reduce times 1-1/2% for each year of participation.

If you retired as totally and permanently disabled, your basic life insurance reduces at age 65.

Example...

Assume you retired in 1993 at age 64, (for reasons other than total and permanent disability). You retired with 30 or more years of participation and basic life insurance in the amount of $80,000. Your basic life insurance would be reduced by $1,600 each month upon retirement.

$80,000 x 2% = $1,600

$36,000 ($80,000 x 1-1/2% x 30 years = $36,000) of continuing life insurance would remain in effect after all reductions.

Extra accident insurance is canceled at retirement.

If you last worked prior to July 1, 1985, the amount of your basic life insurance reduces by 2% each month commencing at age 65.

A 20 year maximum applies to years of participation if you last worked prior to January 1, 1974. Years of participation after age 65, and any changes in salary after age 65, may be used in determining the amount of continuing life insurance, depending on when you last worked.

Minimum Amount of Continuing Life Insurance

If You Last Worked on or After	Minimum* Amount of Continuing Life Insurance
November 15, 1993	$5,000
October 1, 1990 but prior to November 15, 1993	$4,500
November 1, 1987 but prior to October 1, 1990	$3,500
If You Last Worked Prior to November 1, 1987	$3,000

** If eligible.*

Basic Life Insurance Upon Retirement from Layoff or Leave of Absence

If you retire from a layoff or leave of absence prior to age 65 for reasons other than total and permanent disability, and your basic life insurance ceased while on leave or layoff, such coverage will be reinstated upon your retirement. The plan to be reinstated will be the plan in effect as of your retirement effective date.

Notification of Continuing Life Insurance Amount

Depending on your service date and last day worked, the amount of your basic life insurance will reduce monthly or immediately upon retirement, depending on your service date, to an ultimate amount. In either case, you will receive notification when your basic life insurance reduces to its ultimate amount.

Optional Life, Dependent Life, and Personal Accident Insurance

Continuing Optional Life, Dependent Life and Personal Accident Insurance in Retirement

The amount of optional life, dependent life and personal accident insurance for which you were insured at retirement may be continued while your basic life insurance remains in force. The requirement that you have basic life insurance is waived if you were hired (or have an adjusted service date) on or after January 1, 1993 but prior to January 1, 2001 and retired with 10 or more years of participation. If you were hired (or have an adjusted service date) on or after January 1, 2001, you are not eligible to continue optional life, dependent life, or personal accident insurance in retirement.

You may not enroll for, or increase, the amount of optional life, dependent life and/or personal accident insurance during retirement. If you retire from layoff or leave of absence, optional life, dependent life and personal accident insurance will not be reinstated at retirement.

As a retiree, you are required to continue to contribute the full cost of any optional life, dependent life and personal accident insurance coverage you wish to maintain. The GM Benefits & Services Center can inform you of the current contribution rate for your age group.

Rates are subject to change by the insurance company, based on group experience. If you wish your contribution to be deducted from your monthly retirement check, contact the GM Benefits & Services Center.

Optional Life Insurance

Optional life insurance may be continued to age 75.

If you last worked before July 1, 1988, the amount of optional life insurance in force is reduced by 20% at age 66 and by a like amount each year to age 70, at which time it will cancel. If you last worked on or after July 1, 1988, the amount of optional life insurance is reduced by 10% at age 66 and by a like amount each year to age 75, at which time it will cancel.

If your service date is prior to January 1, 2001 and you last worked on or after January 1, 2001 and retire after age 66, the amount of optional life insurance in force as of the day immediately preceding your retirement date will be immediately reduced to the amount in the following schedule based upon your age at retirement.

Optional Life Insurance Reductions

Age at Retirement	Percentage of Insurance in Effect on The Employee's Retirement Date
66	90%
67	80%
68	70%
69	60%
70	50%
71	40%
72	30%
73	20%
74	10%
75	-0-

Dependent Life Insurance

Dependent life insurance may be continued to age 70, provided you have an eligible dependent.

In the event of death of your covered dependent, you are the beneficiary of any dependent life insurance benefits payable.

The definition of a dependent for dependent life insurance is the same as defined under the General Motors Health Care Program for Salaried Employees, except that, sponsored dependents shall not qualify as eligible dependents and same-sex domestic partners and children of same-sex domestic partners who are not otherwise eligible dependents, shall not qualify as eligible dependents prior to January 1, 2003 (see pages 19 – 20). This definition applies to you if you last worked on or after January 1, 1993.

If you last worked on or after January 1, 2003, same-sex domestic partners and their children who are eligible dependents for purposes of health care may qualify as eligible dependents for dependent life and personal accident insurance.

If you last worked prior to January 1, 1993, you must contact the GM Benefits & Services Center for the definition of dependent that applies to you.

You are responsible for notifying the GM Benefits & Services Center at 1-800-489-4646 or 1-877-347-5225 (TTY) when a dependent loses eligibility.

Personal Accident Insurance

Personal accident insurance may be continued throughout your retirement.

If you last worked prior to January 1, 2001, the maximum amount of personal accident insurance available to a retiree upon attainment of age 70 is $100,000 and upon attainment of age 75 will be $50,000.

If you last worked on or after January 1, 2001, the maximum amount personal accident insurance available to a retiree upon attainment of age 70 will be $150,000.

Benefits are payable to your beneficiary (or beneficiaries) if you should die as a result of a covered accident while insured for personal accident insurance. If you do not name a beneficiary (or beneficiaries), any proceeds will be paid to the beneficiary (or beneficiaries) designated for your basic life insurance.

Benefits will be payable to you in the event of your accidental dismemberment or because of any covered accidental loss or losses sustained by your eligible spouse/same-sex domestic partner or dependent child(ren). Benefits are only payable if you, your spouse/same-sex domestic partner or dependent child(ren) sustain an accidental bodily injury and suffer a loss within one year of the accident; provided the loss was not the result partly or wholly due to causes stipulated in the plan. Certain exclusions are listed below:

- suicide, attempted suicide or intentionally self-inflicted injury while sane or insane;
- flight in an aircraft (including boarding and alighting there from) which is being used for (a) any test or experimental purpose, except while performing YOUR duties as an EMPLOYEE of the CORPORATION, or (b) operated by or under the direction of any military authority, other than transport type aircraft operated by the Military Airlift Command (MAC) of the United States of America or similar air transport service of any other country;
- flight in an aircraft (including boarding and alighting there from) while YOU are a pilot, student pilot, or member of the crew, which is being used for (a) flights requiring a special permit from the appropriate civil aviation authority, even if granted, except while performing YOUR duties as an EMPLOYEE of the CORPORATION; or (b) racing or exhibition stunt flying; or (c) skywriting or banner towing; (d) crop dusting, spraying, seeding, or firefighting; or (e) exploration, pipe or power line inspection; or (f) any form of hunting;

- war, or any act of war whether or not during a time of peace;
- physical or mental illness, diagnosis of or treatment for the illness;
- any infection unless it is caused by an external wound that can be seen and which was sustained in an accident;
- the use of any drugs or medicine unless taken on the advice of and in accordance with the direction of a licensed physician;
- service on full-time active duty in the armed forces of any country or international authority at war (any contributions made by YOU for coverage during such period of active duty will be returned to YOU); or
- committing or attempting to commit an assault or felony.

The loss schedule provides benefits if injury results in death or dismemberment within one year after the date of the accident as indicated below:

Schedule of Losses

Loss	**Amount Payable**
Life	Full amount
Speech and hearing	Full amount (two times full amount for child)
Paralysis*	Full amount (two times full amount for child)
Two or more members**	Full amount (two times full amount for child)
One member	One-half the full amount (full amount for child)
Speech	One-half the full amount (full amount for child)
Hearing in both ears	One-half the full amount (full amount for child)
Thumb and index finger of the same hand	One-quarter the full amount (one-half the full amount for child)

* *"Paralysis" coverage is applicable only to your spouse and dependent child(ren).*

** *"Member" as used in the above schedule means hand, foot, sight of eye, speech or hearing in both ears.*

Note: The full amount payable will not exceed $100,000 while the insured is flying as a pilot, student pilot, or member of the crew. This limitation does not apply to commercial air travel.

Only one amount, the largest to which you are entitled, is paid for all losses sustained by one covered individual resulting from one accident. For example: You suffer an accidental bodily injury resulting in one of the losses described on this page, entitling you to a payment of one-half the full amount of your coverage (e.g. loss of one hand). In the same accident, you suffer another bodily injury resulting in one of the losses described on this page, entitling you to a payment of the full amount of your coverage (e.g. loss of sight in both eyes). The amount paid to you will only equal the full amount (i.e. the greater amount) because the total amount paid to you for losses resulting from the same accident cannot exceed the total amount of personal accident insurance in force.

An additional benefit of up to ten percent (10%) of the full amount in force may be payable for you, your spouse/same-sex domestic partner, or your child, as applicable, (up to a maximum of $25,000) if you, your covered spouse/same-sex domestic partner or covered child suffer a loss of life as a result of a covered accident which occurs on or after January 1, 2001 in a private passenger car and the covered person's seat belt was properly used. An additional benefit of ten percent (10%) of the covered person's full amount in force (up to a maximum of $25,000) will also be payable if an air bag is deployed for the seat which the covered person occupied and while properly using a seat belt.

If you, your covered spouse/same-sex domestic partner, or covered child suffer a loss of life as a result of a covered accident and the death occurs 100 miles or more away from the covered person's principal residence, an additional benefit of $5,000 is payable for the preparation and transportation of the covered person's body to the city of the person's principal residence.

An eligible dependent child for purposes of personal accident insurance is the same as defined under dependent life insurance. If you last worked prior to January 1, 1993, you must contact the GM Benefits & Services Center for the definition of dependent that applies to you. You are responsible for notifying the GM Benefits & Services Center at 1-800-489-4646 or 1-877-347-5225 (TTY) when a dependent loses eligibility.

Failure to Make Required Contribution for Basic Life, Optional Life, Dependent Life and/or Personal Accident Insurance

If you fail to make a required contribution, your basic life, optional life, dependent life or personal accident insurance will cease at the end of the month preceding the month for which the applicable contribution was due.

Beneficiaries

Beneficiary Changes After Retirement

You may name anyone you wish as your beneficiary (or beneficiaries) for your optional life and personal accident insurance. The beneficiary need not be the same as you designate for your basic life insurance. You are always the beneficiary of dependent life or personal accident insurance payable as the result of the death of an eligible dependent. If an applicant owner or assignee is the owner of the optional life or personal accident insurance on your life, then the applicant owner or assignee has the right to designate the beneficiary.

You may designate a beneficiary by accessing the Beneficiaries link at gmbenefits.com. If you do not have web access, you may obtain a beneficiary designation form by contacting the GM Benefits & Services Center at 1-800-489-4646 or 1-877-347-5225 (TTY).

Death of Designated Beneficiary

It is important for you to name a new beneficiary if your present beneficiary dies. Therefore, you should immediately access the Beneficiaries link at gmbenefits.com or contact the GM Benefits & Services Center for the appropriate form. If there is no beneficiary living at the time of your death, your basic life insurance may be paid to your estate, or in a manner other than that which you may have desired. This may result in legal and tax problems for your survivors.

If you last worked on or after January 1, 1993, and you (or your applicant owner or assignee, if applicable) fail to name a beneficiary for your optional or personal accident insurance, any proceeds will be paid to the beneficiary (or beneficiaries) designated for your basic life insurance.

Disqualification, Ineligibility, Denial, Loss, Forfeiture, Suspension, Offset, Reduction or Recovery of Benefits

The following circumstances may result in disqualification, ineligibility, denial, loss, reduction or recovery of benefits. The circumstances include but are not limited to: failure to comply with program eligibility rules, non-payment of premium, any benefit plan overpayment due to any reason, end of continuance period, termination of the plan, quit, discharge, proof of good health denial, insufficient years of participation, sufficient length of service, and state of residence.

In the Event of Death

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In the Event of Death

In the event of your death during retirement, benefits may be payable to your eligible survivors under the Life and Disability Benefits Program, the Retirement Program, and the Savings-Stock Purchase Program. In addition, coverage may be available under the Health Care Program. Life Insurance benefits available under the Life and Disability Benefits Program are discussed below. Information concerning survivor's benefits available under the Retirement Program is discussed on pages 90 – 91. Information concerning your Savings-Stock Purchase Program and health care coverage for your survivors is discussed on pages 91 – 92.

Life Insurance Benefits in the Event of Death

The benefits available to you and your eligible survivors are those provided under the Life and Disability Benefits Program in effect when you last worked for General Motors.

The information below may answer questions you have concerning any life insurance benefits that may be payable under the Program. If you have a specific question about life insurance benefits that is not answered here, you may wish to contact the GM Benefits & Services Center, toll free, at 1-800-489-4646 or, for the hearing/speech impaired, at 1-877-347-5225.

Payment of Basic Life, Optional Life, and Personal Accident Insurance

Your basic life, optional life, personal accident, and any extra accident insurance that may be payable, is payable to the latest beneficiary (or beneficiaries) you have designated, provided the beneficiary (or beneficiaries) is alive at your death. If you are uncertain who your beneficiary is, you may wish to contact the GM Benefits & Services Center, toll free, at 1-800-489-4646 or for the hearing/speech impaired at 1-877-347-5225.

To apply for life insurance benefits, a beneficiary will be required to complete a claim form provided this purpose. The procedure is the same for basic life, extra accident, survivor income benefits, optional life, dependent life insurance and personal accident insurance. To report a death, the beneficiary should call the GM Benefits & Services Center at 1-800-489-4646 or 1-877-347-5225 TTY.

Beneficiary Payment Options for Life Insurance Upon Death of Retiree

If the benefit from a single claim is $5,000, or more, your beneficiary may receive basic life insurance benefits under one of the several options available under the Beneficiary's Total Control Account Program® (TCA). The TCA Program provides your beneficiary with total control of the proceeds from your life insurance. A personalized checkbook allows your beneficiary to easily use all, or a portion, of the money. Funds left with the insurance company earn interest at competitive rates. Several investment options also are available under TCA. A separate brochure describing the TCA options is available, on request, at the GM Benefits & Services Center.

Survivor Income Benefit Insurance

Only Retirees Who Last Worked Prior to January 1, 1993 Can Be Eligible for Survivor Income Benefit Insurance

Survivor income benefit insurance is canceled at age 65. Survivor income benefit insurance provides monthly payments to an eligible survivor following the death of an insured retiree. Two kinds of monthly survivor income benefits may be provided, transition benefits and bridge benefits.

To apply for survivor income benefits, an eligible survivor will be required to make a claim on a form provided for that purpose. ***To do this, your survivor should contact the GM Benefits & Services Center, toll free, at 1-800-489-4646.***

Transition Benefits

Transition benefits are monthly benefits payable during the 24-month period following your death, if you are insured for survivor income benefits. These monthly benefits may be paid to your eligible spouse, dependent children, or dependent parents, in that order. The monthly amount of any transition benefit depends on (1) when you last worked, (2) whether your survivors are eligible for certain Social Security benefits, and (3) the amount of survivor benefits payable under the Retirement Program.

Bridge Benefits

Bridge benefits are monthly benefits payable to your surviving spouse after payment of the 24th transition benefit. These benefits are payable until your surviving spouse dies, remarries, or attains age 62*, or such lower age at which full widow's or widower's insurance benefits, or Retirement Insurance Benefits, become payable under Social Security.

The monthly amount of any bridge benefit depends on when you last worked and the amount of survivor benefits payable under the Retirement Program.

Bridge benefits are not payable for any month for which a surviving spouse could qualify for a mother's or father's insurance benefit under Social Security, whether or not the survivor actually receives the mother's or father's benefit.

To receive bridge benefits, your spouse must meet age and other eligibility requirements.

* *Age 62 and one month for a surviving spouse who attains age 62 on or after March 1, 1982, and who receives a Social Security Retirement Insurance Benefit, which is paid during the second month following the survivor's 62nd birthday.*

Can My Spouse Receive Survivor Income Benefits Under the Life and Disability Benefits Program and Also Receive Survivor Benefits Under the Retirement Program?

Prior to January 1, 1989, benefits were not payable under both Programs at the same time. Effective with benefits payable on and after January 1, 1989, survivor benefits may be payable concurrently under both Programs; however, the survivor income benefit under the Life and Disability Benefits Program will be reduced by the monthly amount of any Retirement Program Part A Basic benefit to which the surviving spouse is entitled. To the extent survivor income benefit insurance exceeds the Part A retirement benefit, the excess amount will be paid.

Continuance of Dependent Life Insurance Upon Death of Retiree

If your service date is between November 1, 1987 and January, 1, 2001, dependent life insurance may be continued following your death, provided the required contributions are made, as indicated below.

If you last worked on or after November 1, 1987 and prior to January 1, 1993, and die while dependent life insurance is in force, your surviving spouse may continue this coverage while your spouse is eligible for either (1) a survivor income benefit under the Life and Disability Benefits Program or (2) a survivor's benefit under the General Motors Retirement Program for Salaried Employees.

If you last worked on or after January 1, 1993, and prior to January 1, 1998, your surviving spouse is only required to be eligible for a survivors' benefit under the General Motors Retirement Program for Salaried Employees to qualify for continuance of dependent life insurance for the period described above. If your surviving spouse is not eligible for such benefit, your spouse may still continue dependent life insurance, but

only for a maximum period of two years following your death.

If you last worked on or after January 1, 1998, your surviving spouse may continue dependent life insurance if it was in effect on the date of your death, whether or not eligible for a survivors benefit under the General Motors Retirement Program.

If you last worked on or after January 1, 2003, your surviving spouse/same-sex domestic partner may continue the dependent life insurance in force at the time of your death.

Your spouse/same sex domestic partner may continue dependent life insurance coverage until the earliest of (1) remarriage, (2) establishment of a new same-sex domestic partnership (3) age 70, or (4) death.

Contribution for Dependent Life Upon the Death of the Retiree

If you last worked prior to January 1, 1998, the monthly rate of contribution of any eligible surviving spouse/same-sex domestic partner will be determined under the applicable schedule, based on the progressing age of the deceased retiree, as though the retiree continued to be living.

If you last worked on or after January 1, 1998 the monthly rate of contribution of any such surviving spouse will be determined under the applicable schedule, based on the progressing age of the surviving spouse.

Death of Your Dependent

Benefits are payable to you if an eligible dependent should die while you are insured for dependent life or personal accident insurance.

Generally, an eligible dependent includes your spouse and dependent children from the moment of live birth. Effective January 1, 2003, the definition of dependent was expanded to include your same-sex domestic partner and or the dependent children of your same-sex domestic partner provided they are eligible to be covered under the provisions of the General Motors Salaried Health Care Program.

To apply for life insurance benefits, you will be required to complete a claim form provided for this purpose. To report a death, you should call the GM Benefits & Services Center at 1-800-489-4646 or 1-877-347-5225 TTY.

Retirement Program Benefits in the Event of Your Death

The following may help answer questions which you may have concerning any survivor benefits that may be payable under the Retirement Program. If you have any additional questions, you may wish to contact the GM Benefits & Services Center by calling 1-800-489-4646.

Survivor Benefits Payable Under the Retirement Program in the Event of Your Death

If you retired on or after January 1, 1962, you may have provided a lifetime monthly benefit for your surviving spouse in the event of your death. This surviving spouse coverage generally became effective at retirement, if you then were married. If you did not elect this coverage, you may have elected the “special” survivor option, which is explained on page 91.

If you retired prior to attaining the earliest age of eligibility for the survivor coverage, you will be contacted by GM just before the survivor coverage will become available to you. At that time, in order for the coverage to become effective, you must provide proof of your marriage and your spouse’s age.

Effect of Survivor Coverage Election

Your monthly Part A basic benefit and Part B benefit are reduced if you have surviving spouse coverage in effect. The percent of reduction depends upon (1) the difference in age between you and your spouse, and (2) your date of retirement.

Amount of Survivor Benefit Under the Retirement Program

The amount of any monthly benefit payable to an eligible surviving spouse generally is based on a percentage of the benefit payable to the retiree. The amount of any monthly survivor benefit that may be payable is shown on your copy of your retirement authorization form, Authorization of Monthly Benefits, which you, or your deceased spouse, received at the time of retirement. You have been advised of any increases in the amount of the survivor benefits which have occurred since you, or your deceased spouse, retired.

Election of Part A Survivor Coverage for New Spouse Following Marriage or Remarriage After Retirement

If you had elected Part A survivor coverage for your prior spouse, or were not eligible to elect the coverage because you were not married when the coverage would have been effective, you may elect the survivor coverage for your present spouse. See page 11 for further information. Contact the GM Benefits & Services Center for information.

Rejection of Survivor Coverage

The surviving spouse coverage is not available to you as a retiree if you rejected the coverage while it was otherwise eligible to you.

Revocation/Rescission of Survivor Coverage in the Event of Death of Spouse or Divorce

As indicated on page 11, you must provide GM a copy of the death certificate, or a certified copy of final court decree of divorce that provides for such rescission. Revocation of the Part A survivor coverage due to death is effective the first day of the month following the date of the death of your spouse upon receipt by GM, of evidence satisfactory to GM, of your spouse's death. In the event your divorce decree provides for rescission and appropriate documentation is furnished, the rescission is effective the first of the month following the month of receipt of evidence satisfactory to, and approval of, GM.

"Special" Survivor Option

In 1968, certain retirees who did not have regular Part A survivor option in effect were given an opportunity to elect a "special" survivor option to provide survivor benefits for their designated spouse. This "special" option, if elected, now provides a lifetime monthly survivor benefit of $13.10 for each year of the deceased retiree's credited service, reduced if the employee retired early at the employee's option.

Payment of Survivor Benefits Under the Retirement Program

If you die while surviving spouse coverage is in effect, survivor benefits under the Retirement Program become payable automatically on the first of the month following the month in which you die.

Savings-Stock Purchase Program (S-SPP) Assets in the Event of Your Death

If you have an S-SPP account at the time of your death, all assets are payable to the latest beneficiary designated by you, provided the beneficiary is alive at your death. ***If you are married,*** your beneficiary must be your spouse, unless your spouse had agreed earlier, in writing, on forms satisfactory to the Administrator, to the designation of some other person(s) as beneficiary to receive your

S-SPP assets. ***If you are not married*** and have not designated a beneficiary, assets in your S-SPP account will be distributed to the beneficiary designated to receive the proceeds of your ***basic life insurance*** under the GM Life and Disability Benefits Program.

Personal Retirement Income Plan (PRIP)

If you have participated in the PRIP and have assets in a Putnam account, your survivor should contact Putnam at 1-800-343-0909 to determine eligibility for any distribution.

Health Care Coverages for Survivors in the Event of Your Death

Under current Program provisions health care coverages are available to:

- A surviving spouse of a retiree receiving or eligible to receive Corporation contributions for coverage in retirement. The spouse must be enrolled or eligible to be enrolled for coverage as of the date of the retiree's death. The surviving spouse may enroll in and/or continue core and non-core coverages with Corporation contributions;

- A surviving spouse of a retiree eligible to continue coverage in retirement on a self-paid basis. The spouse may elect to enroll in and/or continue core and non-core coverages on a self-paid basis.

If your surviving spouse is eligible to continue coverage, he/she may continue coverage for dependent children enrolled at your death, provided they continue to meet the eligibility criteria applicable to dependent children.

Health care coverages are ***not*** available to:

- A surviving spouse of a former employee eligible only for ***deferred vested retirement benefits***;

- A spouse or former spouse receiving, or eligible to receive, only a ***pre-retirement survivor benefit*** under the Retirement Plan; or

- A retiree's surviving spouse who is eligible only for ***Sponsored Dependent*** coverage but is not so enrolled as of the date of the retiree's death. If the surviving spouse is enrolled as a Sponsored Dependent as of the retiree's death, a conversion contract may be available.

The eligibility of other surviving spouses is summarized in the chart on page 93. To use the chart, identify the category in the left column that best describes the decedent's status at the time of death. Then move to the right to determine the coverages available, the periods of time they are available and whether or not there are Corporation contributions. In some cases, eligibility varies depending on whether or not the employee's/retiree's continuous employment commenced prior to January 1, 1993. In those cases, the provisions applicable to the pre-1993 hires (service date before January 1, 1993) are in the middle column and those applicable to the 1993 or later hires (service date on or after January 1, 1993) are in the right hand column.

Health care coverages for a retiree's surviving spouse and/or eligible dependent child(ren) acquired after retirement, who are carried as Sponsored Dependents, would cease at the end of the month in which you die. Conversion may be available.

A surviving spouse age 65 or older who is eligible, but is not enrolled for Medicare Part B coverage, is not eligible for GM contributions for any health care coverages. Coverages may be continued on a self-paid basis until Medicare Part B coverage is obtained. After enrollment in Part B is obtained, contributions may be reinstated and continued while Medicare Part B enrollment is maintained.

*SURVIVING SPOUSE ELIGIBILITY**
Salaried Health Care Program

Surviving Spouse of:	Primary Enrollee Hired Prior to January 1, 1993 and dies on or after January 1, 1993	Primary Enrollee Hired On or after January 1, 1993
#1. Employee who dies prior to eligibility for health care coverage	If married to the employee for at least one year prior to the employee's death, the surviving spouse may enroll for core Program coverages on a self-paid basis as follows: ■ For 24 months, or ■ Until the earlier of remarriage, age 62 or death, if the surviving spouse is age 45 as of the date of the employee's death or if the surviving spouse's age and the employee's years of credited service totals 55 or more. ■ Conversion may be available after Program coverage exhausted.	
#2. Employee who dies after eligibility for health care coverage with less than 10 years of credited service	■ If married to the employee for at least one year prior to employee's death, the surviving spouse may enroll in and/or continue core Program coverages as follows: — For up to 24 months at 12 months with Corporation contributions and 12 months at 100% self-paid, or — Beyond the 24 month period above until the earlier of remarriage, age 62 or death, if the surviving spouse is age 45 as of the date of the employee's death or if the surviving spouse's age and the employee's years of credited service totals 55 or more. ■ COBRA available as an alternative to Program coverage. ■ Conversion may be available after Program or COBRA coverage is exhausted.	
#3. Employee who dies with 10 or more years of credited service and not eligible to retire voluntarily	■ If surviving spouse ***is receiving a Part B survivor benefit*** under the Salaried Retirement Program, the Corporation shall make contributions to continue core and non-core coverages until the later of 24 months, or remarriage. Conversion may be available after continuance exhausted.	■ If surviving spouse ***is receiving a Part B survivor benefit*** under the Salaried Retirement Program, the Corporation shall make contributions to continue core and non-core coverages for 12 months. Following this period the surviving spouse may continue coverages on a self-paid basis for an additional 12 months or remarriage. Conversion may be available after continuance exhausted.
	■ If surviving spouse is married to the employee for at least one year prior to employee's death and is not receiving a Part B survivor benefit, core coverages will be available as detailed in #2 above. ■ COBRA available as an alternative to Program coverage. ■ Conversion may be available after Program or COBRA coverage is exhausted.	
#4. Employee who dies after eligible to retire voluntarily	Core and non-core coverages may be continued with Corporation contributions if: (1) The employee was hired prior to 1-1-88 and had 30 or more years of credited service; (2) The employee's age and credited service as of date of death totaled 85 or more and the employee had at least 10 years of credited service; or (3) The deceased employee was age 60 or more and had 10 or more years of credited service as of the date of death and the surviving spouse is receiving a Part B survivor benefit under the Salaried Retirement Program. ■ If employee does not meet (1) or (3) above, the Corporation shall make contributions to continue core and non-core coverages for 12 months after which coverage may be continued on a self-paid basis. ■ If employee has at least 10 years of credited service, and the employee's age, when added to the employee's years of credited service as of the date of death does not equal 85 points, coverages will be available as detailed in #3 above. ■ COBRA available as an alternative to Program coverage. ■ Conversion may be available after Program or COBRA coverage is exhausted.	■ Core and non-core coverages may be continued for 12 months with Corporation contributions. Thereafter, coverage may be continued on a self-paid basis.
#5. Employee who dies from accidental injury caused by employment with GM	Corporation will make contributions for the surviving spouse to enroll in and/or continue core and non-core coverages until remarriage. Coverages and Corporation contributions may continue beyond remarriage if eligible in accordance with #1 through #4 above. ■ COBRA available as an alternative to Program coverage. ■ Conversion may be available after Program or COBRA coverage is exhausted.	

#6. Retiree	■ If surviving spouse was eligible for coverage only as a Sponsored Dependent and was not enrolled as of date of retiree's death, no coverage is available. ■ If surviving spouse was enrolled as a Sponsored Dependent as of the retiree's date of death, conversion may be available. ■ If the retiree's coverage was self-paid in retirement and the surviving spouse was eligible for coverage as a spouse, the surviving spouse may enroll in and/or continue core and non-core coverages on a self-paid basis. Elections and required payment must be made promptly. Conversion may be available. ■ If the retiree was receiving Corporation contributions for coverage in retirement and if the surviving spouse is eligible for coverage as a spouse as of the date of the retiree's death, the surviving spouse is eligible to continue coverages with Corporation contributions for core and non-core coverages.
* *Eligibility for Corporation contributions for a surviving spouse age 65 or older is conditioned on participation in Medicare Part B, if eligible.*	

General Motors reserves the right to amend, change, or terminate these provisions.

Employee Retirement Income Security Act of 1974 (ERISA)

With the exception of the right to amend, modify, suspend or terminate, this section applies only to benefit plans governed by ERISA.

Table of Contents

Types of Plans

The GM Salaried Retirement Program is a defined benefit plan providing trusteed and/or insured retirement benefits to employees who retire and to their eligible survivors. The GM Life and Disability Benefits Program is a welfare benefit plan providing life and disability coverages to retirees and their eligible dependents. The GM Salaried Health Care Program is a welfare benefit plan that provides primarily self-insured benefits to retirees and their eligible dependents. The GM Savings-Stock Purchase Program is a defined contribution plan providing trusteed benefits to employees who elect to participate in this program.

Long-Term Care Insurance is a welfare benefit plan that offers long-term care insurance to:

- Eligible GM salaried retirees and their spouses (issue age 18 and over);
- Surviving spouses of eligible GM salaried employees or retirees, and their spouses (issue age 18 and over); and
- Salaried employees and their spouses (issue age 18 and over), parents and parents-in-law (under issue age 80).

GM Salaried Retirement Program trusteed benefits are provided through the payor bank, Deutsche Bank & Trust Company. Savings-Stock Purchase Program trusteed benefits are provided through State Street Bank and Trust Company. Life insurance, personal accident and Retirement Program insured benefits, are provided through the MetLife. Health care benefits for retirees are provided through carriers such as United HealthCare, Blue Cross-Blue Shield, a number of local plans providing the coverages, and health maintenance organizations. Long-Term Care insured benefits are provided through John Hancock Life Insurance Company.

Plan Year

December 31 is the end of the plan year for the Life and Disability Benefits Program, Salaried Health Care Program, Savings-Stock Purchase Program and Long-Term Care Insurance. Records of these plans are kept on a calendar year basis. The GM Salaried Retirement Program plan year ends on September 30.

Named Fiduciary

The Investment Funds Committee of General Motors Corporation is the Named Fiduciary of the benefit plans described in this booklet that are governed by ERISA. General Motors Investment Management Corporation (GMIMCo) is the Named Fiduciary of the plans for the purposes of investment of plan assets.

Administrator

General Motors Corporation is the sponsoring employer and administrator of the benefit plans described in this booklet that are governed by ERISA. The administrator's address is Mail Code 482-C26-A68, 300 Renaissance Center, P.O. Box 300, Detroit, MI 48265-3000.

Identification Numbers

General Motors' employer identification number is 38-0572515. Plan numbers are as follows:

Program/Plan Name	*Number*
GM Salaried Retirement Program	001
Savings-Stock Purchase Program	002
Life & Disability Benefits Program	501
Salaried Health Care Program	524
Long-Term Care Plan	528

Legal Process

Service of legal process on General Motors Corporation may be made at any office of the CT Corporation. CT Corporation, which maintains offices in all 50 states, is the statutory agent for services of legal process on GM. The procedure for making such service generally is known to practicing attorneys. Service of legal process also may be made upon GM at the Service of Process Office, GM Legal Staff, 400 Renaissance Center, Mail Code 482-038-210, Detroit, Michigan 48265-4000.

For Long-Term Care Insurance

Service of legal process of John Hancock Life Insurance Company may be made to the Group Long-Term Care Division, 200 Clarendon Street, C7, P.O. Box 111, Boston, MA 02117.

Participant Rights

As a participant in the GM benefit plans which are governed by ERISA, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

- Obtain a statement telling you whether you have a right to receive a retirement benefit at normal retirement age (age 65) and, if so, what your benefits would be at normal retirement age if you stop working under the plan now. If you do not have a right to a retirement benefit, the statement will tell you how many more years you have to work to get a right to a retirement benefit. This statement must be requested in writing and is not required to be given more than once every twelve (12) months. The plan must provide the statement free of charge.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a

preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

- In addition to creating rights for plan participants, ERISA imposes duties upon the persons who are responsible for the operation of employee benefit plans.

- The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension or welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

- If your claim for a benefit is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

- Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

- If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a Federal court.

- The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

- If you have any questions about your plan, you should contact the plan administrator.

- If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

Benefit Guaranty

Your pension benefits under this plan are insured by the Pension Benefit Guaranty Corporation (PBGC), a federal insurance agency. If the plan terminates (ends) without enough money to pay all benefits, the PBGC will step in to pay pension benefits. Most people receive all of the pension benefits they would have received under their plan, but some people may lose certain benefits.

The PBGC guarantee generally covers: (1) normal and early retirement benefits; (2) disability benefits if you become disabled before the plan terminates; and (3) certain benefits for your survivors.

The PBGC guarantee generally does not cover: (1) benefits greater than the maximum guaranteed amount set by law for the year in which the plan terminates; (2) some or all of benefit increases and new benefits based on plan provisions that have been in place for fewer than 5 years at the time the plan terminates; (3) benefits that are not vested because you have not worked long enough for the company; (4) benefits for which you have not met all of the requirements at the time the plan terminates; (5) certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the plan's normal retirement age; and (6) non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay, and severance pay.

Even if certain of your benefits are not guaranteed, you still may receive some of those benefits from the PBGC depending on how much money your plan has and on how much the PBGC collects form employers.

For more information about the PBGC and the benefits it guarantees, ask your plan administrator or contact the PBGC's Technical Assistance Division, 1200 K Street N.W., Suite 930, Washington, D.C. 20005-4026 or call 202-326-4000 (not a toll-free number); TTY/TDD users may call the federal relay service toll-free at 1-800-877-8339 and ask to be connected to 202-326-4000. Additional information about the PBGC's pension insurance program is available through the PBGC's website on the internet at http://www.pbgc.gov.

Right to Amend, Modify, Suspend, or Terminate

General Motors reserves the right to amend, modify, suspend, increase, decrease or terminate any of its employee benefit plans or programs by action of its Board of Directors (Board) or other committee or individual expressly authorized by the Board to take such action.

Such amendments, modifications, increases, decreases or termination may occur whenever the entities described above deem it to be appropriate.

If an amendment, modification, increase, or decrease occurs, the plans will implement the change consistent with the action of the entities described above.

If a plan or program is terminated, that plan or program will no longer exist and no further benefits are payable from that plan or program unless otherwise specified under federal law or the Plan or Program (i.e., Retirement Program).

The benefits to which an employee is entitled are determined solely by the provisions of the applicable benefit program. Absent an express delegation of authority from the Board of Directors, no one has the authority to commit the Corporation to any benefit or benefit provisions not provided for under the applicable benefit program, or to change the eligibility criteria or any other provisions of such program.

Salaried Retirement Program

In the event that the GM Salaried Retirement Program is partially or totally terminated, the amount of assets available to provide benefits shall be allocated in the levels of priorities stated below, less expenses for administration or liquidation:

- Mandatory employee contributions;

- In the case of benefits payable as an annuity:
  - In the case of benefits in pay status three years prior to termination (at the lowest pay level in that period and at the lowest benefit level under the Program during the three years prior to termination); and
  - In the case of benefits that would have been in pay status three years prior to termination had the participant been retired (and had the participant's benefits commenced then, at the lowest benefit level under the Program during the three years prior to termination);

- All other benefits of individuals under the Program that are guaranteed under the plan termination insurance provisions of ERISA, determined without regard to Section 4022 of ERISA;

- All other nonforfeitable benefits under the Program; and

- All other benefits under the Program.

In the event of termination or partial termination of the Program, the rights of all affected employees to benefits accrued to the date of such termination, partial termination, or discontinuance, to the extent funded as of such date, is nonforfeitable.

Life and Disability Benefits Program and Health Care Program

Upon termination or partial termination of either Program, coverage will cease as of the effective date of termination or partial termination.

Savings-Stock Purchase Program (S-SPP)

Upon termination, or partial termination, of the S-SPP, no further contributions will be made to the accounts of participants. Participants will maintain entitlement to vested benefits held in their account.

Long-Term Care Insurance

Upon termination of the plan, coverage will cease as of the effective date of termination. All insured persons may continue this coverage in effect under a replacement policy or under a conversion policy issued by John Hancock Life Insurance Company.

Trustees

Trustees of the Retirement Program, who accumulate assets through which trusteed retirement benefits (Part A and Part B supplementary) are provided, are as follows:

J.P. Morgan Chase Bank
3 Chase Metrotech Center
Brooklyn, NY 11245

State Street Bank and Trust Company
One Lincoln Street
State Street Financial Center Boston, MA
02111-2900

Some retirement benefits (Part B primary) are provided through the following insurance companies:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, Connecticut 06115

Metropolitan Life Insurance Company
One Madison Avenue
New York, New York 10010-3690

Prudential Life Insurance Company
Prudential Plaza
Newark, New Jersey 07101

The Trustee of the Savings-Stock Purchase Program, who accumulates assets through which benefits are provided, is:

State Street Bank and Trust Company
One Lincoln Street
State Street Financial Center
Boston, MA 02111-2900

Application and Claims Review Procedures

Disability Claims

To receive benefits under the Plan, you will need to file an application. Appropriate forms are available by contacting the GM Benefits & Services Center.

Initial Determination

After your application is received, your eligibility for benefits will be determined, and you will be advised accordingly.

If your application for benefits is denied in whole or in part, written notice will be made to you as soon as practicable but generally no later than 45 days (unless special circumstances require an extension) after receipt of your application. This notice will include specific reasons for the denial and will refer to the plan provisions upon which the denial is based. The notice also will include a description of any additional information that may be needed if the claim is to be resubmitted. An explanation of the procedure by which you may have your denied claim reviewed also will be included in the notice.

Appealing the Initial Determination

Within 180 days following receipt of the formal notification letter from the carrier that a disability claim has been denied, you may request in writing to have the claim reviewed. The request for review should be submitted in writing to the carrier and must include at least the following information:

- Name of employee;
- Name of plan;
- Reference to the initial decision; and
- An explanation why you are appealing the initial determination.

As part of the review, you may submit any data or written comments to support the claim. A written decision will be furnished within a reasonable time, but not later than 45 days (90 days if special circumstances require an extension of time) after the request for review is received. The written decision will include specific reasons for the decision and will set forth specific reference to plan provisions upon which the decision is based. The carrier has discretionary authority to construe, interpret, apply and administer the Program.

Voluntary Appeal Process

If you are not satisfied with the decision of the carrier, the Corporation provides for an additional voluntary level of review as follows: You may appeal within 60 days to the Plan Administrator. You may initiate such an appeal by writing the Plan Administrator, at Mail Code 482-C26-A68, 300 Renaissance Center, P.O. Box 300, Detroit, MI 48265-3000. As part of the review, you may submit any data or written comments to support the claim. The Plan Administrator has discretionary authority to construe, interpret, apply and administer the Program.

If you are still not satisfied with the decision, you may appeal within sixty (60) days to the Employee Benefit Plans Committee (EBPC) which has been delegated authority to construe, interpret, and administer General Motors' employee benefit plans. The decision of the Employee Benefit Plans Committee is final and binding. You may initiate such an appeal by writing the Secretary, EBPC, at Mail Code 482-C26-A68, 300 Renaissance Center, P.O. Box 300, Detroit, MI 48265-3000.

Life and Accidental Death or Dismemberment Benefits Claims

Initial Determination

After the carrier receives your claim for benefits, the carrier will review your claim and notify you of its decision to approve or deny your claim.

Such notification will be provided to you within a reasonable period, not to exceed 90 days from the date received, unless the carrier

notifies you within that period that there are special circumstances requiring an extension of time.

If the carrier denies your claim in whole or in part, the notification of the claim decision will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because the carrier did not receive sufficient information the claims decision will describe the additional information needed and explain why such information is needed. The notification will also include a description of the Plan review procedures and time limits, including a statement of your right to bring a civil action if you claim is denied after an appeal.

Appealing the Initial Determination

In the event a claim has been denied in whole or in part, you or, if applicable, your beneficiary can request a review of you claim by the carrier. This request for review should be sent in writing to Group Insurance Claims Review at the address of the carrier's office which processed the claim within 60 days after you or, if applicable, your beneficiary received notice of denial of the claim. When requesting a review, please state the reason you or, if applicable, your beneficiary believe the claim was improperly denied and submit in writing any written comments, documents, records or other information you or, if applicable, your beneficiary deem appropriate. Upon your written request, the carrier will provide you free of charge with copies of relevant documents, records and other information.

The carrier will evaluate all the information, will conduct a full and fair review of the claim, and you or, if applicable, your beneficiary will be notified of the decision. Such notification will be provided within a reasonable period not to exceed 60 days from the date we received your request for review, unless the carrier notifies you within that period that there are special circumstances requiring an extension of time of up to 60 additional days.

If the carrier denies the claim on appeal, the carrier will send you a final written decision that states the reason(s) why the claim you appealed is being denied, references, any specific Plan provision(s) on which the denial is based, any voluntary appeal procedures offered by the Plan, and a statement of your right to bring a civil action if your claim is denied after an appeal. Upon written request, the carrier will provide you free of charge with copies of documents, records and other information relevant to your claim. The carrier has discretionary authority to construe, interpret, apply and administer the Program and their decision is final and binding.

Health Care

Mandatory Appeal Procedure

If you wish to appeal an adverse claim determination, you must submit your appeal in writing within 180 days from the initial claim determination. Follow the instructions provided on the Explanation of Benefits (EOB) you receive from the carrier and send your written appeal to the address of the appropriate carrier. In the case of a claim involving urgent care, when the services in question require pre-authorization, you may initiate the appeal by a telephone call to the appropriate carrier.

For an appeal regarding eligibility under the Program, you must direct your written appeal to the GM Benefits & Services Center, P. O. Box 5175, Southfield, MI 48086-5175.

Health Maintenance Organizations (HMOs) and Alternative Dental Plans (ADPs) each have their own appeal process which must be followed in all circumstances, other than questions regarding eligibility for participation in the GM Salaried Health Care Program. If you wish to appeal a claim determination, write directly to the HMO or ADP at the address given on the initial claim determination or in your certificate. HMOs and ADPs are responsible for formulating their own medical policy. Decisions resulting from their appeal process are final.

If you are enrolled in the Basic Medical Plan, Enhanced Medical Plan, Preferred Provider

Organizations or Traditional Dental Plan, and you wish to appeal the denial of a health care claim, write to your local carrier and include in your correspondence the following:

- A copy of the Explanation of Benefits (EOB) you received from the carrier;
- Any additional information/ documentation to be considered;
- The reason why you believe the denial was incorrect.

The carrier will review the information and provide a decision on the appeal within the applicable time period. Some carriers may utilize a two-step process for such appeals. If you are enrolled in an option that has a two-step process, you should follow the instructions on the first appeal response you receive to elevate your appeal to the second step.

Under the mandatory procedure, the carrier has discretionary authority to construe, interpret, apply and administer the Program.

Once you have completed the appeal process offered by the carrier, you may bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 or you may continue to pursue your appeal under the Voluntary Review Process.

Voluntary Review Process

Your decision to submit an adverse claim determination for review under the GM Voluntary Review Process will not have an effect on your rights to any other benefits under the GM Salaried Health Care Program.

You can elect to submit an adverse claim determination for review under the Voluntary Review Process only after exhaustion of the mandatory appeal procedure described above. The carrier's final determination completes the mandatory appeal procedure.

Any statute of limitations or other defense based on timeliness is tolled during the time that the voluntary review is pending. The Program waives any right to assert that you have failed to exhaust administrative remedies because you did not elect to submit a claim determination for review under the voluntary process.

You have a right to legal representation. However, representation is not required under the Voluntary Review Process. The Program will impose no fees or cost for review.

To utilize the voluntary process, submit your written appeal to the GM Benefits & Services Center, P.O. Box 77003, Cincinnati, OH 45277-0066 including with your correspondence the following:

- A copy of the initial EOB;
- Copies of any information you sent to the carrier when you appealed;
- The carrier's decision on the appeal;
- All previous responses;
- The basis for requesting a redetermination; and
- Other pertinent documentation.

The following is a summary of the GM Voluntary Review Process.

Step one is a review by a Benefits Administrator at the GM Benefits & Services Center.

Step two is a review by the Assistant Director of the GM Benefits & Services Center.

Step three is a review by the Plan Administrator whose role is to determine whether the Program provisions have been applied properly. For services determined to be research, experimental or investigational in nature, an additional review step may be made available. The Plan Administrator is required to follow the terms of the Program and has discretionary authority to construe, interpret, apply and administer the Program.

The Plan Administrator will respond in writing by either approving or denying your claim.

For step four, you will then have 60 days to appeal your denied claim by writing to the Secretary of the Employee Benefit Plans Committee (EBPC), Mail Code 482-C26-A68, 300 Renaissance Center, P.O. Box 300, Detroit, MI 48265-3000. As part of this appeal, you must provide any written documentation to support your position that the Program provisions have not been properly applied. Requests for exceptions to the Program provisions may not be appealed to the EBPC.

Under the voluntary process, the EBPC of the Corporation has been delegated authority to construe, interpret, apply and administer the Program, and is the final review authority with respect to the appeal.

Savings-Stock Purchase Program

If you make a claim for benefits under the Program and the claim has been denied, the Program Administrator will notify you or your beneficiary in writing of the specific reasons for the denial. You or your beneficiary will then be given an opportunity for a full and fair review of the decision to deny a claim for benefits by filing an appeal with the Employee Benefit Plans Committee (EBPC) of GM. The EBPC has been delegated final discretionary authority to construe, interpret, apply, and administer the Program. The written appeal must be filed within 60 days form the date of the Program Administrator's written decision denying a claim for benefits.

The appeal must be sent to the Secretary of the EBPC, General Motors Corporation, 300 Renaissance Center, Mail Code 482-C26-A68, Detroit, Michigan 48265-3000. The written appeal should clearly state why you or your beneficiary believe the Program Administrator was wrong in denying your claim for benefits. **The EBPC is the final review authority with respect to appeals, and its decision is final and binding upon GM, you and your beneficiary.** A written decision on the request for review will be furnished to you or your beneficiary within 60 day (120 days if special circumstances required an extension of time) after the date the written request is received by the EBPC.

Retirement Program

General Motors Corporation is the Plan Administrator and has full authority to construe, interpret and administer the Program. The administrator will provide adequate and timely notice in writing to any participant or beneficiary whose claim for benefits under the Program is denied, setting forth the specific reasons for such denial. Any denied claim may be appealed to the Plan Administrator within 60 days. The request must be made by writing the Plan Administrator at Mail Code 482-C26-A68, 300 Renaissance Center, P. O. Box 300, Detroit, MI 48265-3000.

The participant or beneficiary will be given an opportunity for a full and fair review by the Named Fiduciary or its delegate of the decision of the Plan Administrator denying the claim. If a participant or beneficiary is not satisfied with the decision of the Plan Administrator, an appeal may be filed with the Employee Benefit Plans Committee (EBPC), which has been delegated the authority necessary to construe, interpret, and administer the Program. Such an appeal must be filed in writing within sixty (60) days from the date of the notice from the Plan Administrator denying a claim for benefits under the Program. The decision of the EBPC shall be final and binding upon the Corporation and the participant or beneficiary.

With the exception of life insurance and long-term care, which are insured, and HMOs, and ADPs, which have their own exclusive claims review procedure, if you are not satisfied with the decision, you may appeal within 60 days to the Employee Benefit Plan Committee (EBPC) that has been delegated authority to construe, interpret, and administer General Motors' employee benefit plans. You may initiate such an appeal by writing the Secretary, EBPC, at Mail Code 482-C26-A68, 300 Renaissance Center, P.O. Box 300, Detroit, MI 48265-3000. ***The decision of the Employee Benefit Plans Committee is final and binding upon GM, you and your beneficiary.*** A written decision on the request for review will be furnished to you or your beneficiary within 60 days (120 days if special circumstances required an extension

of time) after the date the written request is received by the EBPC.

Review of Long-Term Care Claim Denial

If your claim for LTC benefits is denied, you or your authorized representative will receive a written notice giving the reason for the denial. You will then be entitled to review of that claim denial if:

- You make written request for such review; and
- You send such request to:

  John Hancock
  Group Long-Term Care Division
  P.O. Box 111
  200 Berkeley Street, B-10
  Boston, MA 02117

  within 60 days after receipt of the denial.

John Hancock will then review and make a final decision with respect to the claim appeal for plan benefits. This decision will be in writing, and, if a denial, will include specific reasons for the denial.

This decision will be made promptly, and usually not later than 60 days after John Hancock received the request for review.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

This notice applies to you if you are covered under the GM Salaried Health Care Program (the Program). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Program. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Program when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Program and under federal law, you can request a copy of the Plan Document from the Plan Administrator by calling the GM Benefits & Services Center at 1-800-489-4646.

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What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Program coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage is lost because of the qualifying event. Under the Program, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Program because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Program because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Program because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (under Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Program as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to General Motors, and that bankruptcy results in the loss of coverage of any retired employee covered under the Program, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Program.

When is COBRA Coverage Available?

The Program will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A,

Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Call the GM Benefits & Services Center at 1-800-489-4646.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Program is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to the GM Benefits & Services Center, P.O. Box 770001, Cincinnati, OH 45277-0020 or call the Benefits & Services Center at 1-800-489-4646.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving while receiving 18

months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Program. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Program as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Program had the first qualifying event not occurred. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the GM Benefits & Services Center, P.O. Box 770001, Cincinnati, OH 45277-0020 or call the Benefits & Services Center at 1-800-489-4646.

If You Have Questions

Questions concerning your COBRA continuation coverage rights should be addressed to the contact identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Administrator Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Contact Information

You should contact the GM Benefits & Services Center, P.O. Box 770001, Cincinnati, OH 45277-0020 or call the Benefits & Services Center at 1-800-489-4646, Monday through Friday between 7:30 a.m. and 6:00 p.m. Eastern Time zone, to speak with a Customer Service Associate.

If you have any questions or if you have changed marital status, please call a service representative at 1-800-537-5865.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established federal requirements to improve the availability and portability of health care coverage for workers and their families when they change or lose jobs, and employers are required to provide a certificate of prior health care coverage when enrollees lose coverage.

In addition, HIPAA established federal requirements as to how the General Motors Health Care Programs and Health Care Spending Account, collectively referred to in this Notice as the "Plans," may use and disclose protected health information about you for purposes of payment of health care claims and health care operations.

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Portability

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established federal requirements to improve the availability and portability of health care coverage for workers and their families when they change or lose jobs, and employers are required to provide a certificate of prior health care coverage when enrollees lose coverage.

A certificate is to be provided to: (1) an individual who is entitled to elect COBRA continuation coverage when a notice is provided for a qualifying event under COBRA; (2) an individual who loses coverage but is not entitled to elect COBRA continuation coverage; and (3) an individual who has elected COBRA continuation coverage when COBRA continuation ceases. The certificate is also provided upon request of the enrollee within 24 months after coverage ceases.

This certificate may be used by former enrollees if they become covered under a new health plan which has preexisting condition limitations. The plans that have such limitations are required to reduce the length of time individuals have to wait for coverage to take effect for the preexisting condition by the period of time they were covered under a prior plan.

Privacy

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the General Motors Health Care Programs and Health Care Spending Account, collectively referred to in this Notice as the "Plans," may use and disclose protected health information about you for purposes of payment of health care claims and health care operations. The Plans may also use and disclose protected health information for other purposes that are permitted or required by law as described below. Although HIPAA also allows the Plans to use and disclose protected health information for treatment purposes, the Plans generally do not engage in treatment.

Protected health information (or "PHI") is individually identifiable health information collected from you that is created or received by a health care provider, a health plan, or a health care clearinghouse, and that relates to (1) your past, present, or future physical or mental health or condition; (2) the provision of health care to you; or (3) the past, present, or future payment for the provision of health care to you.

Access to PHI is restricted to persons who need it to carry out their job duties in administering the Plans. Use and disclosure is limited to the minimum necessary to accomplish the intended purpose.

This Notice applies to covered dependents as well as primary enrollees.

Our Responsibilities

In accordance with the law, the Plans are required to implement reasonable measures to preserve the privacy of your PHI and to provide notice to you regarding:

(1) Uses and disclosures of PHI;

(2) The Plans' obligations relating to the privacy of your PHI;

(3) Your health information rights concerning your PHI;

(4) Your right to file a complaint with either the Plans or the Secretary of the U.S. Department of Health and Human Services; and

(5) Contact information for use in obtaining additional information with respect to the Plans' policies and procedures for handling PHI. The Plans are required to abide by the terms of this Notice until a revised notice is issued in accordance with HIPAA.

Your Rights with Respect to PHI

You have the following individual rights with respect to your PHI:

(1) You have a right to access your PHI. You have a right to inspect and copy your PHI. Generally, the Plans' records containing your PHI are claims payment records and associated documents.

(2) If you believe that your PHI is incorrect or incomplete, you may request an amendment to the information. The Plans are not required to agree to the amendment, but if it is denied, you have a right to submit a statement of disagreement to be kept with the disputed record.

(3) You have the right to request restrictions on certain uses and disclosures of PHI. For example, you may request that the Plans refrain from disclosing your PHI to other persons, such as family members, even for permitted uses. Under certain circumstances, the Plans are not required to agree to a requested restriction.

(4) If you believe that a disclosure of your PHI may endanger you, you may request that the Plans communicate with you regarding your PHI in an alternative manner or at an alternative location.

(5) You have a right to an accounting of certain disclosures of your PHI if your PHI has been disclosed for reasons other than treatment, payment for health care, or health care operations.

(6) You have a right to a paper copy of this notice.

To exercise these rights you may write to the address listed in the Contact Information section of this notice. To request claim payment records containing your PHI, you may also contact the customer service department of your health care carrier directly. You may be asked to submit your request in writing.

How Your Protected Health Information May Be Used

Treatment: While the Plans generally do not engage in treatment, the Plans are permitted to use or disclose your PHI for that purpose.

Payment: The Plans may use and disclose your PHI to pay claims associated with treatment and services that you receive by virtue of your enrollment in the Plans. Such purposes include, but are not limited to, eligibility determinations, claims processing, precertification or pre-authorization, billing, coordination of benefits, and subrogation. For example, PHI may be used to pay a doctor's bill for covered services rendered by that doctor while treating you.

Health Care Operations: The Plans may use and disclose PHI about you for day-to-day plan operations. Such purposes include, but are not limited to, business management and administration, customer service, enrollment, audit functions, fraud and abuse detection, quality assurance, and disease management. For example, the Plans may use claims information to respond to claims appeals or audit the accuracy of claims processing. If you have a Health Care Spending Account, your PHI may be used to process reimbursements.

Business Associates: The Plans contract with Business Associates to provide certain types of administrative services. To perform these functions or to provide the services, the Business Associates may receive, create, maintain, use, or disclose PHI. For example, the Plans may disclose your PHI to a Business Associate to administer claims or to provide customer service. The Business Associates will be required to agree in writing to appropriately safeguard your PHI. Examples of our Business Associates are Blue Cross Blue Shield of Michigan, United HealthCare and Medco Health. In some cases, Business Associates may also contract with third parties to perform certain functions or to provide services.

Plan Sponsor: The Plans may disclose PHI to General Motors Corporation in its capacity as plan sponsor for purposes associated with sponsorship of the Plans. For example, the Plans may disclose PHI to General Motors Corporation in its capacity as plan sponsor for the purpose of considering plan enhancements. Generally, the information disclosed is summarized data and does not identify individuals personally.

Required by the Law: The Plans may use or disclose PHI about you as required by state and federal law. For example, the Plans may disclose your PHI when required by national security laws or public health disclosure laws. The Plans are required to disclose your PHI to the Secretary of the U. S. Department of Health and Human Services when the Secretary is investigating or determining the Plans' compliance with HIPAA.

Legal Proceedings: The Plan may disclose your PHI: (1) as required by law in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal; and (2) in response to a subpoena, discovery request, or other lawful process, under the conditions required by applicable law.

Workers' Compensation: The Plans may disclose your PHI to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries.

Other Permitted Uses and Disclosures: The law permits the Plans to make the following types of uses and disclosures under certain circumstances. While the Plans generally do not use or disclose PHI for these purposes, they may disclose PHI to: a health oversight agency (such as Medicare or Medicaid); for government functions (for reasons of national security); to avert serious health or safety threat; or for post-mortem identification.

Other Uses: Other uses and disclosures require your written authorization. For example, an authorization is required for any use or disclosure of psychotherapy notes, except in connection with a legal action or other proceeding brought by the Individual who is the subject of the notes. If you provide an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of PHI requiring authorization.

Complaints and Inquiries

You may file a complaint with the Plans or the Department of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with the Plans, you may write to the address below. You will not be retaliated against for filing such a complaint.

Future Changes in the Notice

The Plans reserve the right to change their privacy practices and the terms of this Notice, making the new notice provisions effective for all PHI maintained by the Plans. The revised Notice will be provided by mail. In the future, you may have the option of receiving the Notice electronically.

Contact Information

For your convenience, this Notice is also available at: privacy.gm.com/gpc/index.shtml, identified as "HIPAA Privacy Notice." For assistance, or to obtain a copy of this notice, you may contact the GM Benefits & Services Center at gmbenefits.com, call 1-800-489-4646 or write to:

GM Health Care Privacy Office
Mail Code 483-520-092
2000 Centerpoint Parkway
Pontiac, MI 48341-3146.

Glossary of Key Terms

Sometimes, in order to accurately describe a benefit plan, it is necessary to utilize technical terms. To help you better understand them, the following are brief definitions of some of the most commonly used terms. They are not meant to be all inclusive as each Plan or Program may have specific usages which may vary.

Programs for GM salaried retirees, referenced here are:

- Savings-Stock Purchase Program (S-SPP),
- Salaried Retirement Program (SRP),
- Salaried Health Care Program (SHCP), and
- Life and Disability Benefits Program.

Account — Assets credited to the participant in the trust fund established under the S-SPP.

Alternative Dental Plan (ADP) — A dental plan that provides services on pre-paid or fee-for-service basis to participants in a designated geographic area.

Ambulance Services — Medically necessary transportation and life support services furnished within the SHCP provisions to sick, injured, or incapacitated patients by a licensed ambulance provider meeting program standards, utilizing ambulance vehicles, and personnel recognized as qualified to perform such services at the time and place where rendered.

Annual Base Salary — For the purposes of determining the amounts of various coverages, annual base salary means: (a) 12 times your monthly base salary, or (b) your annual earnings base, if you are compensated wholly or partially on a commission basis; and including any premium for necessary continuous seven-day operations immediately preceding your retirement.

Approved Facility or Treatment Program — a facility or a treatment program that has met criteria established by the carrier to provide certain services covered by the GM Health Care Program. The following are examples of facilities and treatment programs which must be approved by the applicable carrier for full benefits to be paid:

- hospitals
- skilled nursing facilities
- outpatient mental health facilities
- substance abuse treatment facilities
- outlets for prosthetic or orthotic appliances
- freestanding physical therapy facilities
- home health care programs
- hospice programs
- freestanding ambulatory surgical centers (FASCs)
- hemodialysis programs

In addition, certain services are not payable under the GM Health Care Program unless rendered by approved facilities or on approved equipment. Some services also must meet certain medical criteria. The following are examples of services which must be rendered by approved providers:

- magnetic resonance imaging (MRI)
- extracorporeal shock wave lithotripsy (ESWL)

- positron emission tomography (PET scans)

In addition, Computerized Axial Tomography (CAT) scan services must be rendered on approved equipment. If you have any doubts about the approved status of a facility or treatment program, you should contact the appropriate health care carrier.

Assets — Securities and cash in the participant's S-SPP account.

Beneficiary — The person, persons, or entity named by you, a plan participant, to receive the plan's benefits when you die — or if you die prior to receiving a benefit due you.

Benefit Period — A period of time during which an enrollee is entitled to receive certain covered services that are subject to Salaried Health Care Program maximums.

Business Day — Any day the New York Stock Exchange is open for business.

Carrier — Any entity by which the various benefit program coverages are administered or benefits paid. The term includes, but is not limited to, the following:

- General Motors Corporation;
- An insurance company; and/or
- Nongovernmental administrative services organizations.

COBRA — **C**onsolidated **O**mnibus **B**udget **R**econciliation **A**ct of 1985 as amended — federal legislation providing continuation rights to certain employees or dependents whose coverage under company-sponsored programs results in a loss of coverage due to certain "qualifying events."

Conversion — An opportunity to obtain other available coverage on a self-paid basis, from the carrier with which enrolled at the time eligibility is terminated.

Core Coverage —Hospital, surgical, medical, prescription drug, hearing aid, mental health, substance abuse, and Extended Care Coverages.

Covered Expenses — Means the reasonable and customary, pre-established, or contracted charges incurred for covered materials and services provided or rendered to or for an enrollee for treatment of illness or injury, and performed by a provider or prescribed by a physician in accordance with the provisions of the Salaried Health Care Program.

Covered Service — Means a service that is included within the range of services identified in the Program, and that meets all Salaried Health Care Program requirements to be eligible for payment of benefits. A service within the range of those identified in the Salaried Health Care Program (e.g., a diagnostic radiology service) but that does not meet all of the specifications to be eligible for benefit payment (e.g., medically necessary) is considered a noncovered service.

Credited Service — Includes all periods of regular employment for which you were paid. This period of time is used to determine eligibility for and amount of benefits under the Retirement Program. May also be used for eligibility purposes by other Programs and/or Plans.

Current Market Value — The value of your assets invested in the S-SPP's Promark Funds, GM $1-2/3 Par Value Common Stock Fund, DIRECTV Group Common Stock Fund, News Corporation Common Stock Fund, Delphi Common Stock Fund, EDS Common Stock Fund and Raytheon Common Stock Fund as may be applicable, based on the unit values as

determined each business day by the Trustee. Also, the value of assets invested in the Mutual Funds based on the share values as determined each business day by the Mutual Fund provider.

Custodial or Domiciliary Care or Services — Means the type of care or service which, even if ordered by a physician, is primarily for the purpose of meeting personal needs of the patient or maintaining a level of function (as opposed to specific medical, surgical, or psychiatric care, or services designed to reduce the disability to the extent necessary to enable the patient to live without such care or services).

Custodial or domiciliary care generally does not require the continuing attention of medically skilled personnel, and usually can be provided by aides or other persons without special skills or training, operating without direct medical supervision. It may include, but is not limited to, help in getting in and out of bed, walking, bathing, dressing, toiletting, meal preparation and eating, taking of medications, ostomy care, bed baths, hygiene or incontinence care, checking of routine vital signs, routine dressing changes, and routine skin care.

The determination as to the nature of the care is not a function of the setting (e.g., hospital, skilled nursing facility, nursing home, another institutional setting, or the patient's home) or of the professional status of the person (e.g., physician, nurse, therapist, or aide) rendering the service, but of the severity of the patient's illness and the intensity of services being performed. The carriers or Utilization Review Organization shall have discretionary authority to interpret, apply, and construe this provision of the SHCP. The carrier's determination as to the nature of the care being provided shall be given full force and effect unless it is determined by the Plan Administrator that the determination was inconsistent with the Program provisions or arbitrary and capricious.

Deferred Vested Benefits — Vested benefits that become payable at a future date, from the retirement program that vested employees or vested former employees are entitled to receive.

Deferred Savings — S-SPP contributions deducted from an employee's eligible salary before federal income taxes and other taxes (if applicable) are determined (i.e., pre-tax employee contributions).

Durable Medical Equipment — Equipment that is able to withstand repeated use, is primarily and customarily used to serve a medical purpose, and is not generally useful to an enrollee in the absence of illness or injury.

Emergency Room Services — Services in the emergency room of a hospital are covered for the initial examination and treatment of conditions resulting from accidental injury or medical emergencies. A medical emergency is a permanent health threatening or disabling condition, other than an accidental injury, which requires immediate medical attention. The condition must be of such a nature that severe symptoms occur suddenly and unexpectedly and that failure to render treatment immediately could result in significant impairment of bodily function, cause permanent damage to the patient's health, or place the patient's life in jeopardy. The patient's signs and symptoms verified by the treating physician at the time of treatment, and not the final diagnosis, must confirm the existence of a threat to the patient's life or bodily functions. A medical emergency will be considered to exist only if medical treatment is secured within 72 hours of the onset of the condition.

If services are rendered in an emergency room and the carrier determines the condition is not the result of an accidental injury or was not a medical emergency, the facility charges are not covered even though the professional charges of the physician may be covered (i.e., the charges comparable to an office visit).

Covered facility services and expenses are reimbursed based on charges or consistent with "reasonable and customary" levels and/or the contractual arrangements that may exist between the carrier and the hospital. If Blue Cross-Blue Shield (or any other carrier that has participating agreements with hospitals) is your BMP, EMP, or PPO carrier, coverage for services obtained from other facilities may be reduced.

ERISA — The **E**mployee **R**etirement **I**ncome **S**ecurity **A**ct of 1974, as it may be amended from time to time.

Exchange — An exchange is a transfer of S-SPP assets from one investment fund to another.

Extended Care Coverage (ECC) — Coverage for certain hospital, skilled nursing facility, or home health care and other services that last beyond the base plan coverage limits, or that are not covered under the base plan because they are generally custodial in nature.

Freestanding Ambulatory Surgical Center — A facility, separate from a hospital, in which outpatient surgical services are provided. Such facilities must meet SHCP standards and be approved by the local carrier.

Freestanding Outpatient Physical Therapy Facility — A facility, separate from a hospital, that provides outpatient physical therapy services. Such facilities must meet SHCP standards and be approved by the local carrier.

GM Benefits & Services Center — A service center through which GM employees, retirees, and surviving spouses may obtain services regarding their benefits. The Center processes various benefit-related transactions, provides general benefit-related information, and assists with problem resolution. The Center also provides services regarding account information and transactions under the S-SPP Program, benefits under the Salaried Retirement Program, and benefits under Layoff Benefit Plan. The Center maintains an Internet website at gmbenefits.com.

gmbenefits.com — The GM Benefits & Services Center Internet website which provides information and online services regarding benefits for GM employees.

Health Maintenance Organization (HMO) — An organization that provides health care services on a pre-paid basis for participants in a designated geographic area. Enrollees generally must use HMO physicians and facilities in order to receive benefits.

HIPAA — Health **I**nsurance **P**ortability and **A**ccountability **A**ct of 1996 — Federal legislation intended to improve the availability and portability of health care coverage, which requires employers to provide a certificate of prior health care coverage when an enrollee loses coverage.

Home Health Care (HHC) — Care or services provided in the home for a patient who is essentially homebound, but whose condition does not warrant care in an institutional setting (such as a hospital or skilled nursing facility). The care/service is generally skilled, part-time and intermittent in nature.

Hospice Program — A program of medical and nonmedical services provided for terminally ill enrollees and their families through agencies that administer and coordinate the services. A hospice program must meet SHCP standards and be approved by the local carrier.

Intermittent Care — Means part-time care (see definition for "part-time care") that is provided on ***less than a daily basis*** or up to eight hours per day of skilled nursing and home health aide services combined, delivered on a daily basis, but for a ***temporary period not to exceed one month***.

Length of Service (Service Date) — Represents your current continuous period of employment with General Motors. This service is used to determine participation in certain Programs or Plans.

Monthly Base Salary — For purposes of determining amounts of coverage, "monthly base salary" means your regular rate of pay the month immediately preceding retirement without overtime, night-shift premium or any other payment, but does not include premium for necessary seven-day operation.

Mutual Fund — An investment company whose business is to invest in the securities (stocks, bonds, and money market instruments) of other companies, banks, governments, or municipalities. All mutual funds have a stated investment goal. The investment company buys securities it believes will help to meet the defined investment objective.

Non-Core Coverages — Dental and vision coverages.

Orthotic Appliance — An external device intended to correct any defect of form or function of the human body.

Out-of-Pocket Maximum — The most enrollees in a health care plan option will pay in deductibles and copayments for most covered expenses during a calendar year.

Part A (Retirement Program) — The noncontributory part of the Retirement Program.

Part B (Retirement Program) — The part of the Retirement Program that offers additional monthly benefits and requires eligible employees to make contributions. General Motors also contributes to Part B of the Retirement Program.

Part B Credited Service — The period of time you contribute to Part B of the Retirement Program, providing contributions remain in the Program. This service is used in calculation of supplementary benefits available under Part B of the Retirement Program.

Participating or Approved Provider — Any hospital, skilled nursing facility, outpatient physical therapy facility, home health care agency, physician, dentist, or other provider of health care services which, at the time an enrollee receives services included under SHCP, meets Program standards and has entered into a contract or agreement with a carrier to provide those health care services in accordance with this Program. Such contract or agreement shall include a provision that the provider accepts the amount of covered expenses, as determined by the carrier, as payment in full (unless otherwise provided). Providers who are not participating providers may or may not participate for individual claims and accept the amount determined by the carrier as payment in full. Use of a non-participating hospital for non-emergency inpatient or outpatient treatment may result in the application of benefit

payment maximums which could leave an enrollee with responsibility for a substantial portion of the reimbursement required by the non-participating provider for such treatment.

Part-Time Care — Means up to and including 28 hours per week of skilled nursing and home health aide services combined, ***for less than eight hours per day*** or ***up to 35 hours per week for less than eight hours per day***, subject to individual review and approval by the carrier.

Physical Therapy and/or Functional Occupational Therapy — Therapy directed toward improving or restoring the level of musculoskeletal function lost due to illness or injury, the development of new function attainable following surgery, or, if for a chronic or congenital condition, significantly improving the condition in a reasonable and predictable period of time. Physical therapy generally pertains to large muscle use and functional occupational therapy to fine motor activities.

Physician — Means a doctor of medicine (M.D.) or osteopathy (D.O.) legally qualified and licensed to practice medicine or osteopathic medicine and/or perform surgery at the time and place services are rendered or performed. As used herein, physician shall also include the following categories of limited-practice professionals who are legally qualified and licensed to practice their specialties at the time and place services are performed, and who render specified services they are legally qualified to perform:

- "Dentist" means doctor of dental surgery (D.D.S.) or a doctor of medical dentistry (D.M.D.) whose scope of practice is the diagnosis, prevention, and treatment of disease of the teeth and related structures;

- "Podiatrist" means a doctor of podiatric medicine (D.P.M.) or a doctor of surgical chiropody (D.S.C.) whose scope of practice is the diagnosis, prevention, and treatment of ailments of the feet. Services of podiatrists, relating to the foot (including the ankle), may be covered under the surgical and medical coverages. A podiatrist also may prescribe medications that may be covered under the prescription drug coverage; and

- "Chiropractor" means a doctor of chiropractic (D.C.) whose scope of practice is the diagnosis and treatment of subluxation or misalignments of the spinal column and related bones and tissues that produce nerve interference. Services of chiropractors that may be covered are limited to diagnostic radiological services and emergency first-aid (as set forth in an administration manual published by the Control Plan), both pertaining to the spine and related bones and tissues.

  Under the SHCP, a chiropractor may not prescribe medications or perform invasive procedures or incisive surgical procedures, provide outpatient physical therapy services, nor perform physical examinations not related to the spine and related bones and tissues.

Primary Plan — Refers to the health care plan responsible to pay first when the covered person has coverage under more than one plan.

Predetermination — A review process performed by a carrier or Utilization Review Organization prior to treatment to determine if proposed treatments, services, or facilities may be appropriate.

Preferred Provider Organization (PPO) — An arrangement with selected doctors, hospitals and other providers within a geographic area to provide care on a fee-for-service basis. PPO

enrollees must use PPO physicians and facilities in order to receive the maximum benefit under the plan.

Principal — The initial amount invested not including earnings.

Prime Rate — The interest rate banks charge to their most credit-worthy customers.

Private Duty Nursing — Care or services provided by a nurse pursuant to a contract with a patient and/or a patient's family/personal representative. The services may be skilled or unskilled, therapeutic or custodial in nature and may be provided in any setting. Generally, the care contracted for is in excess of the care provided by an institution (such as a hospital or skilled nursing facility) or the part-time/intermittent/skilled care provided by a home health care agency.

Prospectus — A thorough, written description of a new security issue, a savings plan, or mutual fund.

Prosthetic Appliance — An artificial device that replaces an absent part of the body, or which aids the performance of a natural function of the body without replacing a missing part.

Reasonable and Customary Charge — As it relates to covered health care expenses, unless otherwise specified, means the actual amount a provider charges for such services rendered or materials furnished, but only to the extent that the amount is reasonable, as determined by the carrier, taking into consideration, among other factors, the following:

- The usual amount that the individual provider most frequently charges the majority of patients or customers for a similar service rendered or materials furnished;
- The prevailing range of charges made in the same geographic area by providers with similar training and experience for the service rendered or materials furnished; and
- Unusual circumstances or complications requiring additional time, skill, and experience in connection with the particular service rendered or materials furnished.

The carrier is responsible for determining the appropriate reasonable and customary charge for a given provider, service, or material. The carrier shall have discretionary authority to interpret, apply, and construe this provision of the SHCP. The determination by the carrier as to the reasonable and customary charge shall be final and conclusive, and shall be given full force and effect unless it is determined by the Program Administrator to have been contrary to the SHCP provisions or it is proven that the determination was arbitrary and capricious.

As used in the SHCP, reasonable and customary also refers to the forms and/or amount of payment used by carriers and preferred provider or similar organizations to reimburse participating or contracted providers for covered services.

Regular Savings — Contributions made by a participant to the S-SPP after federal income taxes and other taxes (if applicable) are deducted from an employee's eligible salary (i.e., after-tax employee contributions).

Return — Profit or loss made on an investment in the form of capital appreciation or depreciation, interest, dividends, or other income.

Rollover — A transfer of cash attributable to the taxable amount of an S-SPP distribution that would be taxable to the participant if not moved directly from one qualified retirement plan to another qualified plan or to an Individual Retirement Account (IRA).

Secondary Plan — Refers to the health care plan that has the secondary obligation to pay benefits when more than one health care plan covers an individual.

Skilled Nursing Care — Care or services that are prescribed by a physician and furnished by a licensed registered nurse (RN) or licensed practical nurse (LPN). The services may be provided on a continuous (as in a hospital or skilled nursing facility) or on an intermittent/part-time basis. The patient must be under treatment and/or convalescing from an illness or injury that requires ongoing evaluation and adjustment of care. The nature of the service and skills required for safe and effective delivery, rather than the patient's medical condition, determine whether the service is skilled.

Skilled Nursing Facility (SNF) — A facility providing convalescent and long-term illness care with continuous nursing and other health care services by, or under the supervision of, a physician and a registered nurse. The facility may be operated either independently or as part of an accredited general hospital. A skilled nursing facility must meet SHCP standards and be approved by the local carrier.

Surviving Spouse Coverage — Automatically provides retirement benefits for your eligible spouse in the event that you die before your spouse.

Therapeutic Care — Specific and definitive surgical, medical, psychiatric, or other care provided to a patient whose condition continues to improve due to the treatment being received. It is provided with the expectation that the patient's level of disability will be reduced, within a reasonably predictable period of time, to enable the patient to function without such care. The improvement must be observable and documented by objective measurement. If a patient's condition stabilizes and further improvement is not reasonably predictable, continuing care will be considered maintenance in nature.

Total and Permanent Disability (T&PD) — Where based on medical evidence satisfactory to General Motors, the employee is found to be wholly and permanently prevented from engaging in regular employment at the location last employed.

Total Control Account Program — Provides a beneficiary with control of the proceeds from GM life insurances, including ready access to the money and earnings/interest on money remaining in their account.

Trustee — The entity responsible for holding the benefits or assets of a Program or Plan. GM's current Trustees are listed on page 99.

Utilization Review Organization — An organization retained to perform certain utilization review and utilization management functions, including predetermination, concurrent and retrospective utilization review.

A Check List of Important Items to Remember

INFORM the GM Benefits & Services Center at 1-800-489-4646 or gmbenefits.com if…

- your dependents change
- your beneficiary dies
- you want to change your beneficiary
- you need an application form for a new vehicle refund allowance
- you have a question about the amount of your retirement benefits
- you marry or divorce and want to elect or reject survivor coverage and are eligible to make such election
- you want to have federal or state income tax withheld from your retirement check
- you want to change your address of record
- your marital status changes
- your spouse dies
- you, your spouse or a dependent become eligible for Medicare Part B
- you become eligible for Social Security Disability Insurance Benefits

INFORM the GM Benefits & Services Center at 1-800-489-4646 if you have an S-SPP account and…

- you want to change your address of record
- your S-SPP beneficiary dies
- you want to change your S-SPP beneficiary
- you have questions on your account

CALL the GM Benefits & Services Center to request a change of address form. Return the completed form to the GM Benefits & Services Center to change your address.

USE your Social Security number in all of your communications to General Motors.

CONTACT your local Social Security office if you have any questions about Social Security or Medicare.